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- Are you a possible victim of "health care reform" - "managed care" - "primary care" vs. "specialty care"? *REGULATED
NOT IN CARE*
- Where are we?
Can your medical organization be of help?
- What's happening with(in) American Medical Association?
- What's happening with(in) Colorado Medical Society?
- What's about to happen in the State Legislature?
- What can **YOU** do to keep your practice doors open?



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4 years in residency,
countless years working 7 days a week,
thousands of hours on call,
who knows how much in tuition,
and an unspeakable amount
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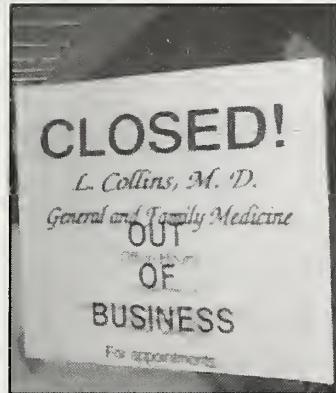
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COLORADO MEDICINE

January, 1996

Volume 93, Number 1



Cover Story

Physicians have (valid) concerns about the future of their profession. Look over the articles in this issue to find out what *your* medical society is doing to help.

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COLORADO MEDICINE

February, 1996

Volume 93, Number 2



Cover Story

What's in the cards? Who's holding the cards? Will the future be a gamble for medical practice? The 21st Century offers a lot of unanswered questions



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COLORADO MEDICINE

March, 1996

Volume 93, Number 3



Cover Story

Yes, we observe "Doctor's Day", but what about recognition by his or her peers? This is an important factor in any profession and we don't want to lose sight of it now. See pg. 87.



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COLORADO MEDICINE

April, 1996

Volume 93, Number 4



Cover Story

What does the future hold for medicine and physicians? As our lives are being rushed to change by electronics, we begin to see some of the extremes embodied in the "Electro-Doc".



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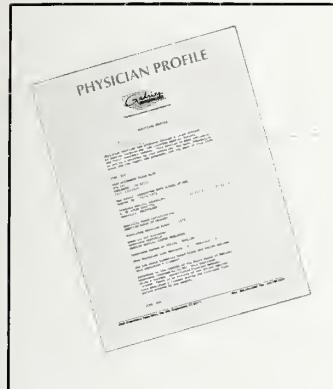
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COLORADO MEDICINE

May, 1996

Volume 93, Number 5



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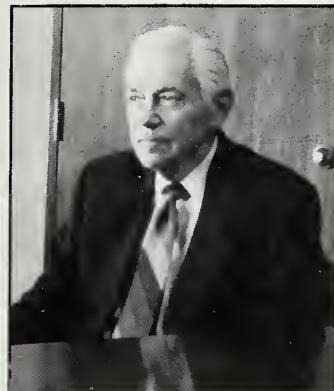
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COLORADO MEDICINE

July, 1996

Volume 93, Number 7



Cover Story

It's about a man's life-long contribution to medicine and the people around him. It's about Frederick A. Lewis, Jr.



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COLORADO MEDICINE

August, 1996

Volume 93, Number 8

Medical Practice in the Year
2000 and BEYOND

Cover Story

How better can we describe what it's all about? "It" is the Annual Meeting and the subject on everyone's mind: "What's happening to medical practice, come the turn of the century?" See **Annual Meeting Section, pp 255-261**



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COLORADO MEDICINE

September, 1996

Volume 93, Number 9

TO: L.B. Golter, MD <lbgolter@ruralhealth.org>
FROM: Ray Painter, MD <rpainter@ucah.net>
SUBJECT: CMS@CMS_Annual Meeting http://www.cbohco.sheraton.com/9_21/1996
List: What's the story on the CMS Annual Meeting educational program?
TO: Ray Painter, MD <rpainter@ucah.net>
FROM: L.B. Golter, MD <lbgolter@ruralhealth.org>
RE: Here is the story on September 21, 1996 at Steamboat Springs

+ James M. Gallo, Enterprise Information Analyst, Publis, Inc, Columbus, OH
+ Roger M. Loebs, Marchex Inc, Boulder, CO
+ Paul M. Loebs, Marchex Inc, San Francisco, CA
+ Terry Forni, DO, San Francisco, CA
+ L.B. Golter, MD (Moderator) WMRIN, Grand Junction, CO

* Does good patient care require a larger hard drive?
* What's the buzz about the computer in the exam room?
* Will there really be a useful computerized medical record?
* Are these computers looking over my shoulder?

Stop all the telemedicine courses and get straight to the interesting material. And then add a few more. The future of medicine is here. The impact of computer and communications technology on the delivery practice of medicine. From the use of computerized medical records to the use of computers in new hardware, software, communications networks, and data mining procedures. Much more to come. See you at the CMS Annual Meeting.

* See page 8 Sheraton Steamboat Resort, Steamboat Springs, CO September 19-22, 1996

Cover Story

"Future message", which says something about all the changes occurring in medical practice. So, what does the future look like? Get a sneak preview, part of the Annual Meeting Educational Program (pg 289).

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COLORADO MEDICINE

October, 1996

Volume 93, Number 10



Cover Story

Domestic Violence: physicians must play a vital role in providing a cure.

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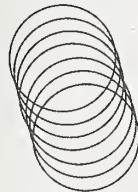


COLORADO MEDICINE

November, 1996

Volume 93, Number 11

January, 1997
Domestic Violence



It all depends on
how you look at it.

Cover Story

The cycle of domestic violence can be broken. Find out what you can do.

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Edie K. Register, Director *Edie_Register@cms.org*
Marilyn Rissmiller, Program Manager *Marilyn_Rissmiller@cms.org*

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Don Rutt, Manager, Support Services *Don_Rutt@cms.org*

Division of Health Care Policy

Ellen J. Stein, Director *Ellen_Stein@cms.org*
Lorraine K. Heth, Program Manager *Lorraine_Heth@cms.org*
Suzi Shevell, Program Manager *Suzi_Shevell@cms.org*

Division of Government Relations

Lorraine L. Koehn, Director *Lorraine_Koehn@cms.org*
K. Suzanne Hamilton, Program Manager/Lobbyist
Suzanne_Hamilton@cms.org

Division of Communications

William S. Pierson, Director *Bill_Pierson@cms.org*
Chet P. Seward, Administrative Assistant *Chet_Seward@cms.org*
Tim Jackson, Advertising Sales Manager, Specialty Media, Inc.
(303) 986-5926

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COLORADO MEDICINE



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Sandra L. Maloney, Executive Editor; William S. Pierson, Managing Editor; Chet Seward, Administrative Asst.



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"Nah,
I've smoked
for
30 years.
It's too late."

"I've tried a
million times,
but I just
can't."

"I'll
quit
next
week."

"What difference does
it make? I'm already
52 years old."

"It's one of the
few pleasures
I have left."

"I've got
other things
to worry about."

"The damage
is done."

They know why they can't. Now tell them how they can.

Too many older smokers are still making excuses instead of making a determination to quit. And while most of them know about the more common long term effects of smoking, far too few of them know the facts about the immediate health benefits of quitting.

As a doctor, you can play a unique role in getting your older patients who smoke to quit for good. Take a little extra time and educate your patients about the immediate benefits of quitting. Like a decreased risk of heart attacks and strokes. Improved circulation. And most of all, the years they can add to their lives.

So listen to their reasons for not quitting, then go ahead and give them the facts.

**Let them know:
it's never too late to quit.**

For a free copy of "Clinical Opportunities for Smoking Intervention: A Guide for the Busy Physician" complete the form below.

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4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814
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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Choice Revisited

The "soul" of our American health care delivery system is the doctor-patient relationship. Previously, I have shared with you my own personal experiences, first as a patient, and then as a physician, which have convinced me that this is the single most important issue for our profession. To preserve the doctor-patient relationship, CMS Leadership is committed to improving patient access and physician choice. Our health care delivery system will function best when we turn its control over to the patient. In such a system, the patient... not the employer... not the government... but the patient, will select and own their health insurance. This will permit the patient to select the health care delivery system and plan which best meet their personal needs. If an ongoing relationship with a physician is important, the patient should be able to select a plan which would permit access to that physician. The current employer-based system often limits choice to plan and physician, resulting in disruption of ongoing professional relationships. Currently, tax treatment of employer contributions to employee health insurance benefits discourages individuals from going outside of employer-sponsored plans. CMS is working through the AMA to push federal legislation allowing for equal tax treatment of health insurance benefits for employers and employees who either purchase coverage in an employer-sponsored plan or purchase insurance away from the place of employment. Such legislation may be considered in early 1996.

To better understand the positions taken by employers and to begin dialogue with them, CMS created the Focus Group on Health Care Issues in June, 1995. We have met one to two times monthly since inception. Patient access issues have been discussed thoroughly, and both CMS and employers have developed better understanding for the other's concerns. It is problematic for employers to have certain health care benefits, even point-of-service (POS), mandated upon them or their insurance carriers. Out of this group have grown

by Joel M. Karlin, M.D., CMS President

several potential free market approaches to improve access. I want to share some of these ideas with you so that you will understand the direction your leadership has decided to take you this year in improving patient access.

CMS has helped to conceptualize the development of an "add-on" indemnity policy which could be purchased by HMO enrollees who seek to have out-of-plan benefits. Many potential products could be developed to provide defined benefits for a range of services. Initial actuarial projections make such a product affordable. The Colorado AMA delegation presented the idea of investigating this and other potential free market solutions to the recent AMA House of Delegates meeting in Washington. The House approved investigation of the feasibility and development of such a product. The AMA will be a major resource for us to help evaluate such a proposal.

I believe the development of Colorado Physician Network/Rocky Mountain HMO in bringing Rocky Mountain Physician Choice Health Plan to the market place will help set the standard by which other HMOs will have to compete. We have the ability to set a new standard of how managed care should be practiced. Please support you fellow physicians and your patients by joining and participating in the plan's development. This concept has been well received by the Focus Group as well as the purchaser and broker communities.

CMS will be investigating the utilization of the Medical Savings Account (MSA) as a vehicle for patient choice. If the needed federal tax laws change this year, such a vehicle could be used by many patients.

Over the last two months, I have represented CMS on the Insurance Commissioner's Committee on Individual Market Reform. If the needed federal tax law changes occur, patients will then have access to purchase health insurance through individual policies. I

Continued following next page...



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, PC. This column is not legal advice, but is for general information only. For help with specific problems, readers should consult an attorney.

Did You Know That:

- ◆ Only 28 states, including Colorado, now have laws guaranteeing patients access to their own medical records. Federal legislation has been introduced by Sen. Bob Bennett (R-UT) giving all Americans the right to inspect their medical records. Significantly, the Medical Records Confidentiality Act would also prohibit holders of medical information from disclosing the information without the patient's permission, except in cases of emergencies, government subpoenas and warrants, for public health purposes and to next of kin.
- ◆ There are 1,800 active healthcare fraud investigations, currently under way, as compared to 365 such investigations in 1991. The FBI will add 100 additional special agents to the 250 already working full-time on healthcare crimes. The head of the FBI's healthcare fraud unit characterizes the current caseload as "just the top of the iceberg. Our caseload could double in the near future." The unit's aggressive approach will include taking a team approach and working extensively with other federal, state and local agencies; regular use of sophisticated investigative techniques such as undercover operations, telephone wiretaps and hidden cameras; aggressive use of temporary restraining orders, asset forfeiture and money-laundering statutes; blending criminal, civil and administrative enforcement instead of concentrating solely on criminal prosecution (for example, Caremark International recently pled guilty to mail fraud and paid \$161 million in fines and penalties for making improper payments to induce doctors and others to prescribe the growth hormone, Protropin); creating national initiatives by combining investigations of similar cases around the country; and identifying target areas, such as Miami, FL, New York, NY and Los Angeles, CA and concentrating efforts and resources there.
- ◆ The AMA, ABA and AARP jointly released a patient guide for the preparation of a combined Living Will and Healthcare Power of Attorney, designed to satisfy most state law requirements. The elements of both are necessary to protect fully the patient wishing to

control his or her healthcare decisions; Living Wills offer protection if the patient is suffering from a terminal condition; the Healthcare Power of Attorney allows the patient to designate an agent to make far-reaching healthcare decisions in the event of the patient's incapacity. Dr. P. John Seward, chair of the AMA Board of Trustees, stated "Each American adult must protect themselves and take the necessary precautions so they are in control of their healthcare decisions. The advance directive form we've created can be used nationwide. It will give patients and their families peace of mind." The free brochure is available by writing to: AARP Fulfillment, 601 E Street NW, Washington, DC 20049. Request stock no. D-15-803.

- ◆ An arbitration panel recently ordered the HMO, Health Net, to pay \$1 million in damages to the surviving family of a deceased breast cancer patient. The panel found that Health Net had engaged in "extreme and outrageous behavior exceeding all bounds usually tolerated in a civilized society" by refusing to pay for an autologous bone marrow transplant and by pressuring the patient's doctor to back off from his support of the costly procedure after her family sued the HMO. In 1993, a jury returned a verdict against Health Net for \$89 million for refusing to pay for a ABMT in a different case.
- ◆ A California jury recently ordered two physicians (who were former hospital board members) to pay the Desert Hospital of Palm Springs \$11.7 million in compensatory damages and \$1.8 million in punitive damages for using inside information of the hospital's expansion plans to develop rival outpatient facilities around the hospital. The hospital had accused the former board members of breaching their fiduciary duty, conspiracy, misappropriation of trade secrets and other violations, including threatening to stop referring patients to other staff physicians who formed partnerships with the hospital.
- ◆ A New Jersey appeals court recently allowed a plaintiff to pursue a claim against a dentist for negligent infliction of emotional distress based upon a fear of contracting AIDS. The plaintiff was stuck in the forearm by a dental instrument while collecting trash from the dentist's office. An investigation showed that the dentist had consciously disregarded state regulatory requirements concerning the disposal of medical waste. The case is unusual in that the plaintiff repeatedly tested negative for HIV after the event, and there was no proof of actual exposure to HIV. The court ruled that in light of the dentist's deliberate disregard of the regulatory controls intended to prevent this type of injury, the law would presume actual exposure to HIV once plaintiff showed an event during which the virus could have been transmitted. The burden then shifts to the dentist to show a lack of actual exposure or to show the unreasonableness of plaintiff's claimed severe emotional distress. The bottom line for the dentist is that, unless the case settles, the claim cannot be resolved without a trial.

CMS Med Fax

Choice Revisited (from Page 1)

am working with consumer representatives on the Committee to push for guaranteed issue of policies irrespective of one's previous health history. We plan to seriously discuss this issue in June after conclusion of the upcoming legislative session.

The Office of Health Care Policy and Finance has become concerned about the accountability of HMOs, particularly regarding quality and patient rights. They have started a process to promulgate new rules and regulations in these areas which will be required for HMO licensure, both new and renewal. CMS has met with the Department to offer input in development of these new standards, and we will continue to be vocal in this process.

We have further evaluated the political climate and the options available for action. The "White Paper on Physician Affiliation/Disaffiliation" provided a good beginning in addressing the individual physician's ability to join and maintain membership in restricted HMO panels. Out of this effort has grown an ongoing working relationship between CMS and the Colorado HMO Association. We have been able to address other contentious issues which previously would have engendered confrontation. One such issue is the OB length of stay, or "drive through delivery" issue. CMS is working in consort with the OB and Pediatric specialty societies to negotiate with the HMOs an acceptable resolution to this problem.

In looking at the issue of patient access today in closed panel HMOs, there are two main areas of concern. The first is the inability of the patient to go "out-of-network" to establish a new doctor-patient relationship. Such access could be provided through a POS plan. The second concern is for the patient in an ongoing doctor-patient relationship whose employer changes health insurance to a plan in which their doctor cannot participate, or their doctor contract is "terminated without cause" from the ongoing plan. We see that as the most acute problem. Such continuity of care is not only important to the quality of care the patient receives, but in most instances, is more cost effective than requiring a patient to transfer care to a new physician who knows nothing about the patient's

particular health history and clinical course. For those patients with chronic illnesses, it takes a physician a significant period of time, often several months to a year, to develop a sense of comfort in caring for a particular patient's illness. To require a patient to then sever such a relationship with their physician and start all over with a new doctor makes little sense. Additionally, patients who are "forced" to break an ongoing doctor-patient relationship and see a new doctor, often are unhappy patients, more likely to look for legal recourse against the new physician and HMO. HMOs, similarly, have the greatest degree of patient dissatisfaction when patients are "forced" out of such ongoing relationships in the treatment of chronic disease.

Your CMS leadership has met twice with the President and attorney for the Colorado HMO Association to discuss our concerns over this continuity of care issue. After consulting with their Board, they have agreed to enter into serious negotiations with CMS to address this issue. We will begin discussions at the upcoming joint CMS/CHMOA meeting scheduled for January 17th. We will create a smaller group which will begin meeting the first week in February. Our agreement is to discuss the issue and develop a mechanism to provide for continuity of care under specified circumstances. The process we will use will be similar to that used in negotiating the "White Paper on Physician Affiliation/Disaffiliation". We have set June 1, 1996, as our target date for such an understanding, agreeing that as long as the CHMOA is negotiating in good faith and progress is being made in the negotiations, CMS will not sponsor or endorse a POS bill in the upcoming session of the Colorado Legislature. We will continue to support and promote our principles of patient choice wherever and whenever possible. We believe that there is more to potentially gain for patients and physicians in this negotiated process than in pursuing a POS bill in the upcoming legislative session. If such negotiations fail, then all agreements are off, and we will both go our separate ways.

I believe the multifaceted approach which I have shared with you will lessen the plight of our patients and physicians. The work has just begun.

CMS Med Fax

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American College of Cardiology

The 27th Annual Cardiovascular Conference at
Snowmass(1617)
January 15-19, 1996
Snowmass, Colorado
Contact: 800-257-4739

American Diabetes Association—Colorado Affiliate

32nd Annual Colorado Diabetes/Endocrine Institute
January 20-25, 1996
Aspen-Snowmass, Colorado
Contact: Becky Burris 303-778-7556

JCAHO/CHA

Accreditation Standards for Laboratories (0408-B1)
January 26, 1996
Denver, Colorado

Peggy McCreary—303-758-1630

Division of Workers' Compensation

Level II Re-accreditation Course
January 26, 26, 1996
Denver, Colorado

Faye Boyd, 303-575-8756

The Eleventh Annual Rocky Mountain Regional Conference on HIV Disease

February 1-3, 1996
Red Lion Hotel
Denver, Colorado
Contact: Colorado AIDS Project, Attn: AIDS Conference, P.O. Box 18529, Denver, Colorado 80218, or call (303) 837-0166

Colorado Medical Society and other health care organizations

Conference on Domestic Violence
February 9, 1995
Embassy Suites, Stapleton
303-393-3292

Division of Workers' Compensation

Level II Physician Accreditation Seminar
February 9, 10, 1996
Denver, Colorado

Faye Boyd, 303-575-8756

Colorado Society of Osteopathic Medicine

Advanced Cardiac Life Support Course
February 24-25, 1996

Keystone Lodge & Resort

15 hours AOA Category 1-A CME credit
Contact: Patricia Ellis at 303-322-1752

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference
February 25-March 1, 1996

Keystone Lodge & Resort

38 hours AOA Category 1-A CME credits; AAFP
prescribed course hours

Contact: Patricia Ellis at 303-322-1752

American College of Cardiology

Workshop on 2-D and Doppler Echocardiography at
Vail

February 26-29, 1996

Vail, CO.

18 Category 1 AMA

Contact: 800-257-4739

CRAHCA/MGMA

The Integrated Health Care Puzzle
March 4-6, 1996

Denver, Colorado

303-397-7881

American College of Cardiology

The 3rd Annual Echocardiography Workshop at Vail
March 26-29, 1996

Vail, Colorado

Contact: 800-257-4739

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on
Inner Ear Medicine and Surgery

March 1996, Aspen, CO.

Contact: Jane Wells or I. Kaufman Arenberg,
MD.(303)778-4235

Colorado Medicine

Cumulative Index

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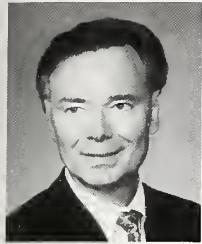
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PRESIDENT'S LETTER



*Joel M. Karlin, MD
President, 1995-1996*



The national debate on reforming our health care delivery system escalated with the election of Bill Clinton as president. The concerns over increasing costs coupled with diminishing access (and increased numbers of uninsureds) led the President and his wife to devise a plan which **they** thought could address the problems. In the development of the Clinton Health Plan, input from practicing physicians was rejected out of hand as self-serving. Surely, no physician, nurse, hospital, or other "provider" could be objective and unbiased. Although our American Medical Association and national specialty societies tried, their input was ignored.

Concerns over the possible passage of the Clinton Health Plan has stimulated the private sector to initiate incredible changes in the way care is provided. With the election of a new, and fiscally conservative, Congress, federal health care programs soon came under scrutiny. This time, however, the input of practicing physicians was sought. The paradigm had changed. Leaders of the majority (Republican) party came to our AMA early this year asking for our help in saving Medicare from projected fiscal insolvency. For 145 consecutive days the AMA staff worked with the Board of Trustees to develop a plan to transform Medicare which embodied AMA policy. The plan, which was submitted to Speaker of the House Gingrich, became the cornerstone of H.R. 2425, the Medicare Preservation Act, which passed the House and was partially modified in the Senate.

The bill rejected the previous federal solution of simply cutting provider reimbursement to save the program. Instead, it created a competitive marketplace allowing economic forces to restrain the rise in program costs. It allowed current Medicare recipients to remain in the current fee-for-service program, or enroll in other delivery systems, including managed care and Medical Savings Accounts. It applied means testing for Part B premiums, and gradually increased the annual deductible. Truly needy seniors would still have funding available for such co-pays and deductibles. It **did not cut** Medicare funding. The current Medicare law incorporates an automatic 9.9% annual increase in funding, irrespective of health care costs or inflation. With health care costs rising at less than 4% annually for the last two years, limiting such annual increase to 7% seemed reasonable. Under the Republican plan, the current \$4,800 per year spent per Medicare recipient would **rise** to \$7,100 over the next seven years.

The House Republican plan included many other pro-patient and pro-physician features, including development of physician sponsored networks to allow physicians to compete with the insurance industry and HMOs; rebates for seniors who enroll in alternative delivery methods of care; many patient protection features; antitrust relief for physician groups; regulatory relief from CLIA (Clinical Laboratory Improvement Act of 1988) in the physician's office and modification of parts of Stark I and Stark II (physician-owned

laboratory self-referral legislation); medical liability reform; graduate medical education funding; medical manpower planning; and ongoing quality assurance.

When the Bill passed the Senate, provisions for medical liability reform were removed. The Joint Conference Committee passed out the bill without CLIA and antitrust relief. The President has, however, vetoed the bill.

Your Colorado Medical Society leadership believes that we must be proactive in promotion of our own principles. To this end, we helped draft the CMS White Paper on Medicare Transformation to publicly present those policies which CMS believes should be included in the final Medicare solution. A copy of that White Paper is included herein. Our CMS Health System Reform Task Force has been directed by our Board of Directors to continue to refine and expand the concepts embodied therein. We forwarded a copy of that position paper to each member of our Congressional delegation, members of the Joint Conference Committee, and the President. Senator Ben Nighthorse Campbell responded in agreement with several items.

During the recently completed meeting of the AMA House of Delegates, we learned that the current Republican Medicare plan agrees closely with our CMS policy. We were told those provisions which had been removed by the Joint Conference Committee will be reattached to the Bill. For the first

(Continued)

PRESIDENT'S LETTER (Continued)

time, our input has been sought, and our policies stand a good chance for implementation. Your AMA has worked hard to help shape the direction of change. It deserves your support.

It was inevitable that the entire issue of Medicare transformation

would become so politicized. The Republican majority is committed to reduce the size of government, and the influence it has on our lives. Balancing the budget is the right thing to do. We must curtail the out-of-control federal spending which jeopardizes the survival of Medicare, and the future of our children.

Congress and the President must do what is right for our patients and the generations to come.

By the time you read this message it will be January. Hopefully there will have been a solution. If not, let your voice be heard. Contact your Congressional representatives and the President. This time we must prevail.

COLORADO MEDICAL SOCIETY WHITE PAPER on MEDICARE TRANSFORMATION

The Colorado Medical Society advocates health care coverage at appropriate medical costs for all Colorado residents. Medicare was created to provide such insurance coverage for health care costs for our senior citizens. Recently, the President's Commission on Medicare questioned the fiscal integrity of the program, calling for fundamental changes to avert insolvency in Medicare Part A by the year 2002. Additionally, the escalating increase in the cost of Medicare Part B jeopardizes the continuity of that program.

There have been different approaches proposed which can be used to contain the costs of the Medicare program. The first approach would be to cut all provider reimbursement without structurally changing the program. That approach would produce temporary success at best, and set reimbursement so low that providers would be unable to accept Medicare patients. Prior to the era of managed care, many providers could afford to accept very low reimbursement for Medicare (often at or below cost), and shift those costs to patients and insurance companies who paid full charges for their care. In today's medical market place, This is no longer possible. Such low reimbursement would lead to access problems for senior citizens unable to find a physician who can afford to care for them.

Another approach to save Medicare would be to develop a marketplace in which competitive forces lead to improved quality and service and lower costs. The Federal Employees Benefits Program, which covers the President, members of Congress, and civil service employees is such a competitive model. It has restrained the rate of rise in health insurance inflation to 6.4% over the last 15 years while the general increase nationally was almost 15%. Such a system empowers the patient to choose A health care delivery system and plan that best meets his/her personal needs. By involving the patient in the selection and financial responsibilities of the plan, the patient becomes a wiser "consumer" of health care.

In considering the alternatives to transform Medicare, the Colorado Medical Society believes any proposal should include the following features:

- reducing the automatic rate of rise in Medicare funding from 10% to a level more reflective of the recent lower health care inflation rate and using these savings to ensure the fiscal integrity of the Medicare programs;
- limitation of increased cost sharing to Medicare recipients with limited financial resources, for example, including mechanisms whereby low income beneficiaries are given assistance in paying for Part B premiums;
- allowing current Medicare enrollees to continue in the government run Medicare program, or opting out into a pluralistic "Medichoice" program. Such a program would provide a variety of health care delivery systems and plans, including fee-for-service, managed care, medical savings accounts and health IRAs. Seniors would be able to continue in employer-sponsored plans if so desired;
- avoidance of precipitous payment rollbacks that could adversely affect access to care by equally sharing any redistribution of provider reimbursement so as not to place undue hardship on any group of providers;
- involvement of physicians in any mid-course corrections needed to maintain quality and access of our senior members to the program;
- professional liability reform;
- creation of provider-sponsored network option for physicians to offer competitive alternatives to insurance plans (federal rather than state insurance regulations);
- provision of antitrust relief so physicians can take advantage of provider sponsored network option and added protection for physician self-regulation activities to promote quality;
- regulatory relief through exemption of physician office labs from CLIA (*Clinical Laboratory Improvement Act of 1967 - Clinical Laboratory Improvement Amendments of 1988*) requirements so that physicians can provide timely in-office laboratory services to patients at a reasonable cost
- overhaul of Stark I and II rules to allow physicians to participate in provision of needed ancillary services to patients;
- protection for patients dealing with managed care plans, guarantees that patients be informed about their rights and responsibilities in managed care, provision of an appeals process in managed care decisions to deselect physicians, disclosure of utilization review criteria, and greater physician input on insurance plan policies;
- creation of a medical education trust to ensure funding for medical education;
- creation of a physician work force planning commission.

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EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



I have just noticed the heading of this piece, a classic misnomer and it may even be an oxymoron. I can't really update anything because I can't catch up to what's going on. 1996 promises to be one of those years where none of us ever catches up to the events in medicine.

The CMS delegation to the AMA meeting in Washington didn't help things either, because we were inundated with issues both proposed and perceived. We were given the political treatment of health care issues, and then came the political treatment of the budget problems. Never in all my life have I seen everything so 'politicized' as it is today.

If I think I am confused, I wonder how the U.S. senior citizens feel today. I'm talking about the ones who are totally Medicare dependent. And what about the Medicaid recipients? Do you suppose they think they even have a future?

Someone, and I won't mention any names, once said "You get two doctors together and you'll have three opinions". Well, that has to be true today about what "medicine" (specifically the traditional practice) should be doing to protect its hindside. I can't keep up. Add to that stew the opinions of all of the 'instant experts' who have literally swarmed over health care like a flock of buzzards over a beef carcass out on the short grass.

While all this is going on, medical practice is awash in the managed care modality, and the docs (a lot of them) don't know whether to stop and put on their boots or just run for high ground.

Organized medicine is trying to help, but the 'new' attitude about health care was one of those phenomena upon us so quickly that we weren't prepared to go with the flow. No one was. At the AMA meeting, one of the major subjects of discussion, report and resolve was the restructuring of the AMA to serve the increasing number of member needs. CMS is working hard to do the same, and I envision the year ahead as one of those periods when scarce little is nailed down. We'll be trying to rebuild the boat while we keep it afloat and under steam, all at the same time.

What can **you** do about all this rush to forever change the face of medicine? You can be well-informed people, applying scientific reasoning to the subject (as physicians are so well equipped) while controlling your emotions. You can then take part in discussion and reasoning on these issues in your own circles, and particularly among the members, leadership and staff of this organization. You can feel free to tell CMS staff members what kind of information you need, and let us see if we can be more effective in fulfilling these information needs.

You can write letters to the editor of any and all publications or periodicals. You can make known your opinions and your beliefs about medicine (still the finest profession and the cornerstone of the best health care delivery system in the world).

Meantime, best wishes for the new year. I hope we can help make it a better year for medical practice.

STOP!
I want to get off!

Or... could we just restart this year from the beginning? because I am terribly confused.

CMS Executive Director installed as President of CPEP Board



Sandra L. Maloney, Executive Director of the Colorado Medical Society, was installed December 14, 1995 as President of the Board of Colorado Personalized Education for Physicians (CPEP). Sandi has long been an active force in CPEP, an organization which custom tailors educational programs to the needs of individual physicians. Also seen at the head table (l to r) are Beth Korinek, Sandi, Kevin Bunnell, PhD, and Jack Mueller, MD. Dr. Mueller and Kevin Bunnell have both long been active in medical continuing education, and have been working with CPEP for a considerable time as well.

LEGAL UPDATE

Trial Testimony

You've been called to testify regarding a patient in front of a Colorado jury. What do you do and what is expected of you?

Part of your professional obligation is to translate your expertise into language that a jury will understand. Trials are adversarial, but you are not an advocate. You are the professional called to provide professional objectivity in assisting the jury to understand the issues surrounding the physical condition of the patient.

Testifying will impact your schedule. Scheduling trial testimony is very difficult. There is no way to know beforehand what events may alter the schedule. Most attorneys schedule professional witnesses first thing in the morning or afternoon, allowing them to obtain the professional's testimony quickly, with a minimum amount of wasted waiting time. Request those time

slots if you can.

Prepare thoroughly for testifying. Review all your records, test results and radiological studies. The more prepared and knowledgeable you are, the better witness you will make. Read all medical assessments of your patient. Do not advocate a position for your patient. Such a stance is painfully obvious to a jury. There is no "right" answer. There is only *your* answer based on your objective, professionally-reasoned opinion.

Meet with and prepare for your testimony with the attorney who will call you as a witness. Professional studies or research concerning your area of testimony enhance the strength of your opinion. Advise the attorney involved so that the research can be endorsed and used at trial.

Common areas for questions are:

- What is your patient's health and injury history and the basis of that history?
- What are your objective and

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

subjective findings regarding diagnosis and treatment and the likelihood of success of the treatment?

—Is there permanency and/or limitation on your patient's social, sexual, work, or recreational activities?

—What is your treatment plan for the future and what is the estimated cost?

—Is your patient doing all he or she can to speed recovery?

—What is your prognosis?

It is important to know your patient to effectively answer these questions. Talk with and examine your patient prior to testifying. The more information you have, the better prepared you will be.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling, P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

Richard Allen wins seat on AMA Council on Medical Education



Richard Allen, MD

At the Interim Meeting of the American Medical Association House of Delegates (Washington, D.C., 12/6/95) Dr. Richard Allen of Denver was elected to the AMA Council on Medical Education.

Dr. Allen is the chairman of the Colorado Medical Society Council on Legislation and is the Director of the Residency Education Program at St. Joseph's Hospital in Denver. His candidacy was endorsed by the CMS, American College of Obstetricians and Gynecologists, American Gastroenterological Association, American Academy of Pediatrics, American Society of Reproductive Medicine and the Rocky Mountain States Council.

Dr. Allen moved to Colorado in 1993 from Oregon where he had served as president of both the county and state medical associations and where he also was an Oregon Delegate to the AMA.

*Richard Allen, MD, Chairman
Council on Legislation*

At this writing, our Colorado Delegation has just returned from the AMA House of Delegates Interim Meeting in Washington, DC. We heard an address by Speaker of the House, Newt Gingrich, and he discussed many legislative items.

By the time you read this, the Colorado legislature probably will have convened, but right now we are in the "lull before the storm".

Bill titles are being lined up and all of the pre-legislative meetings we have had with business and the insurance industry will now become focused on actual legislation. The only bill that we definitely have going forward at this time is the Rural Health bill. Our efforts on Point of Service have been stymied by the Insurance Commissioner's office which feels, once again, that this will have a large fiscal note impact and will thus derail our efforts. After all of the meetings I have had, it is discouraging that they just now have decided this. However, we are still looking at a way to craft some legislation to give some patients' choice and continuity of care.

Also, everyone is awaiting the outcome of the Medicare battle in Congress and whether the states will be given autonomy (but with reduced funding) through block grants. State regulatory authorities are looking now at the Nurse Practice Act, and we will be monitoring this very closely to make sure our issues regarding independent practice and prescription privileges are complied with. CMS has also formed a task force on health system reform and another on managed care to look at

THE LOBBY



various issues ranging from the potential of unauthorized access to medical records by third parties, to quality assurance activities and peer review. The Health Care Reform Task Force and the Council on Legislation are also looking at a proposal which would place all Medicaid patients in managed care programs. The Governor's Task Force on the Uninsured is looking at providing local community grants to the groups who will care for the uninsured, assuming that we are under block grants.

As always we need as many physicians and spouses as possible, to serve as key contacts with state legislators. The more "grass roots" our efforts are, the better chance of success we will have. If you are interested in being a Key Contact person, please notify the Government Relations office at CMS.

There are some changes within the entire federation of medicine which will have a large impact on all of us, so I would encourage you read Dr. Rich Quinn's **AMA Update** report in this issue. Basically, the House of Delegates will be restructured to provide more input from physicians representing their specialty societies rather than their state medical associations. Everything, of course, will be based on AMA membership, and this will be very important for Colorado to have as large a membership in the AMA as possible.

In January the Colorado General Assembly will be in session and we will have a much more complete report on current issues.



What's In Store?

Here are the issues we're expecting to be hot in the 1996 Legislative Session

Executive Director of the State Health & Environment Department

It is expected that the Governor will once again propose legislation which will amend current statutes requiring that the Executive Director of this Department be a physician. As in the past, the governor will attempt to remove this requirement on the basis that this should be the right of his office to appoint anyone he likes and there are not an adequate number of physicians qualified in administration and environment. CMS believes Colorado citizens are best served when a physician is heads this department.

Hospital Districts

The Colorado Hospital Association is considering legislation which will create health service districts to provide health services through licensed facilities without requiring the provision of hospital services. The CMS has reviewed this bill draft.

Laser Surgery for Optometrists

The optometrists will be proposing that they be allowed to treat glaucoma and perform laser surgery. CMS opposes.

Continued Registration of Lay Midwives

CMS will be opposing a Sunrise/Sunset bill which allows for continued registration of lay midwives on the basis that the state should not sanction this practice. There are only 23 lay midwives currently registered in the state. This bill will also allow for dual licensure for this group of practitioners. This means that people registered as acupuncturists or licensed as nurses, physicians, chiropractors, etc. can also be registered as lay midwives.

Medicaid

The State Medicaid Advisory Committee drafted a bill which would place all Medicaid patients in the managed care arena. It is our understanding that this bill will be pulled or re-drafted. CMS will be closely monitoring developments in this area since we had major concerns with the original draft.

Patient Access

It is expected that there will be a bill submitted which will permit persons enrolled in managed care to appeal decisions by a managed care entity via an independent review committee.

The OB/Gyn Society may introduce a bill which will allow this group of physicians to serve as primary care providers in certain circumstances.

Rural Health

CMS is proposing legislation which will set up a mechanism for a loan repayment plan for physicians who agree to practice in rural areas and allow for a tax credit for physicians currently practicing in rural areas.

Telemedicine

The Colorado Radiological Society has drafted a bill which will require a Colorado license for physicians who render services or "interprets tests or images for Colorado residents when the patients have not traveled, for purposes of treatment, to the other state." The CMS has not taken a position on this proposal.

Uninsureds

The Governor convened a Task Force on the Uninsured to determine what, if anything, might be done to cover the population which has no insurance. As of this date, no decision has been made to introduce legislation.

Workers' Compensation Fee Schedule

An effort to utilize a form of the Medicare RBRVS for determining provider compensation continues to lurk on the horizon. CMS is preparing to respond immediately to any such proposal since the McGraw-Hill schedule was adopted this past summer. Worker's Compensation premiums have continued to decrease since enactment of SB 218 ('91) and CMS believes the McGraw-Hill schedule should be given an opportunity to work before any changes are made.

SAVE THIS and the following pages - listing the members of the 1996 Colorado Senate and House of Representatives, their mailing addresses and telephone numbers. These lists are published for the purpose of the Colorado Medical Society Government Relations Division Key Contact program. These contacts could be of vital importance to Colorado physicians during 1996. We urge you to **locate your District legislators and keep these numbers handy.**

Senate

Ben Alexander (R) District 6 P.O. Box 1285 Montrose, CO 81402 249-3211/866-4866	Rob Hernandez (D) District 34 4600 W 36th Ave Denver, CO 80212 458-1011/ 866-4865	Tom Norton (R) District 16 1204 50th Ave. Greeley, CO 80634 353-5360/ 866-3342	Gloria Tanner (D) District 33 2150 Monaco Pky. Denver 80207 355-7288/866-4865
Don Ament (R) District 1 Route 1, Box 142 Iliff, CO 80736 522-8205/ 866-4866	Sally Hopper (R) District 13 21649 Cabrini Blvd. Golden, CO 80401 526-0785/ 866-4873	Pat Pascoe (D) District 32 744 Lafayette St. Denver, CO 80218 832-8865/866-4865	Mary Anne Tebedo (R) District 12 1916 Snyder Ave. Colorado Springs, CO 80909 (719)471-2561/866-4880
Tillman Bishop (R) District 7 2697 G Road Grand Junction, CO 81506 242-9230/ 866-3077	Joan Johnson (D) District 24 7951 York St. #3 Denver, CO 80229 288-9237/ 866-4863	Ed Perlmutter (D) District 20 2795 Juniper Dr. Golden, CO 80401 278-8426/866-4865	Bill Thiebaut (D) District 3 P.O. Box 262 Pueblo 81002 (719)544-3822/866-4865
Tom Blickensderfer (R) District 26 9 Parkway Drive Englewood, CO 80110 758-0146/ 866-2587	Elsie Lacy (R) District 28 11637 E Mexico Ave. Aurora, CO 80012 750-5943/ 866-2587	Linda Powers (D) District 4 P.O. Box 2300 Crested Butte, CO 81224 349-1337/ 866-4865	Dave Wattenberg (R) District 8 Drawer 797 Walden, CO 80480 723-4577/ 866-4866
Lloyd Casey (D) District 23 10434 Carmela Lane Northglenn, CO 80234 452-8515/ 866-4865	Doug Linkhart (D) District 31 38 S Clarkson Denver, CO 80209 733-3569/ 866-4865	Ray Powers (R) District 10 5 N. Marksheffel Rd. Colorado Springs, CO 80929 (719)596-1055/866-4866	Frank Weddig (D) District 29 15818 E 8th Cir. Aurora, CO 80011 366-8762/ 866-4865
Mike Coffman(R) District 27 P.O. Box 440740 Aurora, CO 80044 671-6402/866-4866	Bob Martinez (D) District 25 6462 E. 63rd Ave. Commerce City, CO 80022 287-8111/ 866-4865	James Rizzuto (D) District 2 Box 215 La Junta, CO 81050 (719)384-8388/866-2587	Paul Weissmann (D) District 17 822 Lafarge Ave. Louisville, CO 80227 673-0191/ 866-4865
Gigi Dennis (R) District 5 247 East Idaho Springs Dr. Pueblo West, CO 81007 (719)547-9330/866-4866	Stan Matsunaka (D) District 15 2109 S County Rd 21 Loveland, CO 80537 635-0384/866-4865	Dorothy Rupert (D) District 18 680 Yale Rd Boulder 80303 494-0568/ 866-4872	Jeff Wells (R) District 11 3166 Oak Creek Dr. E Colorado Springs, CO 80906 (719)471-4110/866-3341
Charles Duke (R) District 9 1711 Woodmoor Dr. Monument, CO 80132 (719)481-9289/866-4866	Al Meiklejohn (R) District 19 7540 Kline Dr. Arvada, CO 80005 422-2092/ 866-4866	Bob Schaffer (R) District 14 3284 Silverthorne Dr. Fort Collins, CO 80526 223-7805/ 866-4866	Dottie Wham (R) District 35 2790 S. High Denver, CO 80210 757-0615/ 866-4866
Michael Feeley (D) District 21 13486 W. Center Dr. Lakewood, CO 80228 987-1354/866-4865	Dick Mutzebaugh (R) District 30 9965 S. Wyecliff Dr. Highlands Ranch, CO 80126 791-4063/ 866-4866	Bill Schroeder (R) District 22 4420 S Braun Ct. Morrison, CO 80465 697-8321/ 866-4866	<i>See list of Representatives on following pages...</i>

House of Representatives

Steve Acquafresca (R) District 58 2290 Road S Cedaredge 81413 856-6358/866-2955	Benjamin Clarke (D) District 7 1800 Monaco Pkwy. Denver, CO 80220 322-2611/866-2909	Doug Friednash (D) District 10 3371 S Magnolia St. Denver 80224 758-6715/866-2910	Peggy Kerns (D) District 41 1124 S Oakland St. Aurora 80012 696-7178/866-5523
Jeanne Adkins (R) District 64 6517 N Pinewood Dr. Parker 80134 841-8829/866-2936	Jim Congrove (R) District 27 P.O. Box 357 Arvada, CO 80001 851-8729/866-2962	Russell George (R) District 57 1300 E. 7th St. Rifle 81650 625-3778/866-2945	Wayne Knox (D) District 3 761 S Tejon St. Denver 80223 934-8707/866-2921
Vickie Agler (R) District 28 10289 W Burgandy Ave. Littleton 80127 973-1987/866-2939	Doug Dean (R) District 18 6463 McNichols Ct. Colorado Springs, CO 80918 (719)598-4920/866-2960	Ken Gordon (D) District 9 2323 S Jackson Denver 80210 753-1383/866-2967	Martha Kreutz (R) District 37 6023 S Bellaire Way Littleton 80121 741-4681/866-5510
Debbie Allen (R) District 43 923 S Ouray St. Aurora 80017 695-4920/866-2942	Diana DeGette (D) District 6 P.O. Box 480246 Denver 80228 388-2324/866-2015	Tony Grampsas (R) District 25 3237 S Hiwan Dr. Evergreen 80439 674-7883/866-2061	Doug Lamborn (R) District 20 1155 Kelly Johnson Blvd. #111 Colorado Springs, 80920 (719)471-1441/866-2924
Norma Anderson (R) District 30 10415 W Hampden Ave. Lakewood 80227 986-0397/866-2927	Jim Dyer (D) District 59 P.O. Box 5225 Durango 81302 259-1942/866-2914	Bob Hagedorn (D) District 42 11633 E. 6th Pl Aurora 80010 367-1994/866-3911	Peggy Lamm (D) District 13 P.O. Box 396 Louisville, CO 80027 494-1979/866-2938
Don Armstrong (D) District 36 P.O. Box 734 Aurora 80040 366-7074/866-2912	Lewis Entz (R) District 60 1016 North 11 Lane Hooper 81136 (719)754-3750/866-2963	Bill Jerke (R) District 49 23003 WCR 39 LaSalle 80645 284-6061/866-2907	Joyce Lawrence (R) District 45 47 Briargate Terrace Pueblo, CO 81001 (719)543-5401/866-2922
Chuck Berry (R) District 21 314 Pine Ave Colorado Springs, CO 80906 (719)634-6328/866-2346	Mary Ellen Epps (R) District 19 217 Dexter St. Colorado Springs 80911 (719)392-3861/866-2946	Vi June (D) District 35 7500 Wilson Ct. Westminster 80030 429-1161/866-2843	Gloria Leyba (D) District 2 1014 Lapan St. Denver, CO 80204 623-5676/866-2911
Nolbert Chavez (D) District 5 4619 Tejon St. Denver, CO 80211 477-7426/866-2925	Jeanne Faatz (R) District 1 2903 S Quitman St. Denver 80236 935-6915/866-2966	Bill Kaufman (R) District 51 4056 Davidia Ct. Loveland 80538 669-4009/866-2947	Glenda Swanson Lyle (D) District 8 2080 Emerson Denver 80205 894-0608/866-2959
Ken Chlouber (R) District 61 220 West Eighth Leadville 80461 (719)486-0008/866-2952	Tim Foster (R) District 54 593 Village Way Grand Junction 81503 245-8440/866-2348	Maryanne Keller (D) District 24 4325 Iris St. Wheat Ridge 80033 425-0130/866-5522	Frana Mace (D) District 4 4990 Green Ct. Denver 80221 433-5093/866-2954

House of Representatives

(Continued)

Bill Martin (R)
District 16
3110 Lees Lane
Colorado Springs 80909
(719)634-8729/866-2965

Ron May (R)
District 15
4980 Daybreak Cir. N
Colorado Springs 80917
(719)591-8620/866-5525

Andy McElhaney (R)
District 17
95 W. Boulder
Colorado Springs, 80903
(719)473-9400/866-3069

Gary McPherson (R)
4230-G S. Granby Way
Aurora, CO 80014
690-8252/866-2944

Bud Moellenberg (R)
District 63
6946 County Road R
Kirk 80824
362-4391/866-2940

Marcy Morrison (R)
District 22
302 Sutherland Pl.
Manitou Springs 80829
(719)685-5929/866-2937

Marilyn Musgrave (R)
District 65
403 Deuel
Ft. Morgan, CO 80701
867-3245/866-2937

Alice Nichol (D)
District 34
891 E 71st Ave.
Denver 80229
287-7742/866-2931

David Owen (R)
District 48
2722 Buena Vista Dr.
Greeley 80631
330-9600/866-2943

Phil Pankey (R)
District 38
5763 Shasta Cir.
Littleton 80123
798-5873/866-2953

Mark Paschall (R)
District 29
7903 W 62nd Way
Arvada, CO 80004
940-9020/866-2950

Penn Pfiffner (R)
District 23
38 S Zinnia Way
Lakewood 80228
988-3717/866-2951

Dan Prinster (D)
District 55
P.O. Box 3884
Grand Junction 81502
241-5015/866-2908

Eric Prinzler (R)
District 31
12272 Jacksonn Pl.
Thornton, CO 80241
252-8922/866-2918

Jeannie Reeser (D)
District 32
9883 Pearl St.
Thornton 80229
452-1838/866-2964

Peggy Reeves (D)
District 53
1931 Sandalwood Lane
Fort Collins 80526
482-8952/866-2917

Gil Romero (D)
District 46
1128 Catalpa St.
Pueblo 81001
(719)544-2420/866-2061

Mike Salaz (R)
District 47
124 E 2nd St.
Trinidad 81082
(719)846-9527/866-2948

Todd Saliman (D)
District 11
701 Pearl St. #3
Boulder, CO 80302
444-0727/866-5524

Paul Schauer (R)
District 39
7255 S Jackson Ct.
Littleton 80122
770-3872/866-2935

Larry Schwarz (R)
District 44
686 Custer Cnty Rd. 297
Wetmore, CO 81253
(719)784-3315/866-3540

Carol Snyder (D)
District 33
11756 Elati Ct.
Northglenn 80234
452-7043/866-4667

Pat Sullivan (R)
District 50
2411 19th Ave.
Greeley 80631
352-5066/866-2929

Bryan Sullivant (R)
District 62
P.O. Box 2387
Dillon, CO 80435
262-9254/866-2916

Bill Swenson (R)
District 12
32 Princeton Circle
Longmont, CO 80503
776-0846/866-2920

Jack Taylor (R)
District 56
Box 5656
Steamboat Springs 80477
879-1880/866-2949

Steve Tool (R)
District 52
1001 Shore Pine Ct.
Ft. Collins, CO 80525
226-0363/866-4569

Shirleen Tucker (R)
District 26
615 S Eldridge St.
Lakewood 80228
988-0118/866-2923

Ron Tupa (D)
District 14
3930 Carlock Dr.
Boulder, CO 80303
494-6791/866-2915

Remember:

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues. 1996 will be another critical legislative year to medicine, so help however you can.





by Leigh Truitt, M.D.

Controversies from the literature

For your interest and information, I would like to give you a few references on "hot topics" in health care. Lorraine Heth in the Colorado Medical Society office at 930-0409 or 1-800-654-5653 can fax or mail the articles to you if they are not available in your hospital medical library.

We all have our own bias. Primary care physicians believe that they provide the highest quality and most cost effective care for most common services. Subspecialists are equally certain that a much larger range of diagnoses and procedures need referral. Many managed care organizations are using gatekeepers to place more control in the hands of their primary care panels. There are no definitive answers available but the following articles bear on the question:

Specialty Bias:

- Daniel B. Mark, *et al.*, "Use of Medical Resources and Quality of Life after Acute Myocardial Infarction in Canada and the United States," *The New England Journal of Medicine*, October 27, 1994; 331:1130-1135.
- John Z. Ayanian, *et al.*, "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction," *The New England Journal of Medicine*, October 27, 1995; 331:1136-1141.
- Jerome P. Kassirer, "Access to Specialty Care," (editorial), *The New England Journal of Medicine*, October 27, 1994; 331:1151-1152.

Primary Care Bias:

- Timothy S. Carey, *et al.*, "The Outcomes and Costs of Care for Acute Low Back Pain among Patients Seen by Primary Care Practitioners, Chiropractors, and Orthopedic Surgeons," *The New England Journal of Medicine*, October 5, 1995; 333:913-917.
- Sheldon Greenfield, *et al.*, "Outcomes of Patients with Hypertension and Non-insulin-dependent Diabetes Mellitus Treated by Different Systems and Specialties: Results from the Medical Outcome Study," *Journal of the American Medical Association*, November 8, 1995; 274:1436-1444.
- Stephan D. Fihn, "Physician Specialty, Systems of Health Care, and Patient Outcomes," (editorial), *Journal of the American Medical Association*, November 8, 1995; 274:1473-1474.

Another controversy among physicians is how to get the utilization review monkey off our backs. Surely there must be a better way that involves less of our time and less "hassle!" The following articles indicate that, when physicians own and operate their own managed care organizations, they use the same techniques of utilization management that other MCOs employ even though evidence of efficacy is lacking:

- Budd N. Shenkin, "The Independent Practice Association in Theory and Practice," *Journal of the American Medical Association*, June 28, 1995; 273:1937-1942.
- Eve Kerr, *et al.*, "Managed Care and Capitation in California: How Do Physicians at Financial Risk Control Their Own Utilization?" *Annals of Internal Medicine*, October 1, 1995; 123:500-504.
- Stanley Goldfarb, "Physicians in Control of the Capitated Dollar: Do unto Others ...," *Annals of Internal Medicine*, October 1, 1995; 123:546-547.
- Stephen N. Rosenberg, *et al.*, "Effect of Utilization Review in a Fee-for-service Health Insurance Plan," *The New England Journal of Medicine*, November 16, 1995; 333:1326-1330. • Martin Shapiro and Neil S. Wenger, "Rethinking Utilization Review," (editorial), *The New England Journal of Medicine*, November 16, 1995; 333:1353-1354.

Read the articles and draw your own conclusions. Life is not as simple as some would have you believe. Next month - are there too many physicians and not the right types, i.e., too many specialists and not enough primary care physicians?



*Patti Brown, President
Colorado Medical Society Alliance*

Colorado Medical Society Alliance "Day at the Capitol" Friday, February 23, 1996

8:30 am Old Supreme Court Chambers
Capitol Building, Denver

Washington Update:
Jay Keese, AMPAC
Invited guests

Colorado Update:
Richard Allen, MD, Chairman, CMS Council on Legislation
Lorraine Koehn, Director, CMS Division of Government Relations
Suzanne Hamilton, Program Manager, CMS Division of Government Relations
Jerry Johnson, Colorado Legislative Services, Inc.

Noon **Meet your legislators** at the University Club
1673 Sherman St (861-4267)
Refreshments will be available on a cash basis

12:30 pm **Lunch will be served \$15**
Each county alliance is responsible for their legislators' lunches and confirmed number of reservations. Reservations are required by February 20, 1996.

A "Day at the Capitol" Registration Form

Name: _____

Address: _____

Phone: _____

County Alliance: _____

I will attend lunch @ \$15 each _____

I have enclosed my check payable to CMSA

Mail to: Patti Brown
6865 West Princeton Avenue
Denver, CO 80235
(303) 988-0888



BOARD HIGHLIGHTS

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - November 17, 1995

Copic: Jerome Buckley, M.D., explained that Gadian now has a marketable product, which is being developed now.

CMSA: Ms. Patti Brown, President expressed her gratitude to the Board of Directors for their support of the Alliance efforts to promote the nation-wide effort to "SAVE - Stop America's Violence Everywhere".

AMA Delegation: Richert Quinn, M.D. reported that the delegation to the AMA would be attending the Interim Meeting in Washington, D.C. from December 3-December 6, 1995.

Colorado Physician Network: David C. Martz, M.D. presented an update on the Colorado Physician Network.

Legal Counsel: Robert Montgomery discussed the Conflict of Interest statements which Board members are required to sign each year.

Board of Directors: The Board approved a resolution regarding publication for physicians of third party reimbursement methodology presented by the AMA delegation for submission to the AMA Interim Meeting.

The Board approved the draft action plan from the Data Committee Report. In this plan, CMS takes steps to ensure the integrity of health care data and to help physicians make the best use of it.

CMS reaccredited for CME

The Colorado Medical Society has been resurveyed by the Accreditation Council for Continuing Medical Education (ACCME) and awarded accreditation for 4 years as a sponsor of continuing medical education for physicians.

ACCME accreditation seeks to assure both physicians and the public that continuing medical education activities sponsored by the Colorado Medical Society meet the high standards of the Essentials for Accreditation as specified by the ACCME.

The ACCME rigorously evaluates the overall continuing medical education programs of institutions according to standards adopted by all seven sponsoring organizations of the ACCME. These are: The American Board of Medical Specialties; the American Hospital Association; the American Medical Association; the Association for Hospital Medical Education; the Association of American Medical Colleges; the Council of Medical Specialty Societies; and the Federation of State Medical Boards.



Guidelines on release of health information to be updated

Public Information Guidelines for Colorado Hospitals, Physicians and News Media has been Colorado's guide for more than 50 years to balance the public's interest in medical information with patient, physician and hospital rights.

Each year representatives from print and broadcast media meet with physicians and representatives from hospitals to examine, debate and update the Guidelines.

Last published in 1989, the Guidelines are about to undergo a major review. You are invited to participate.

New issues in the last six years include media coverage of outpatient and home health care, confidentiality and electronic medical records, end of life issues, mental health language and release of information on transplant cases.

You can be part of the discussion in several ways.

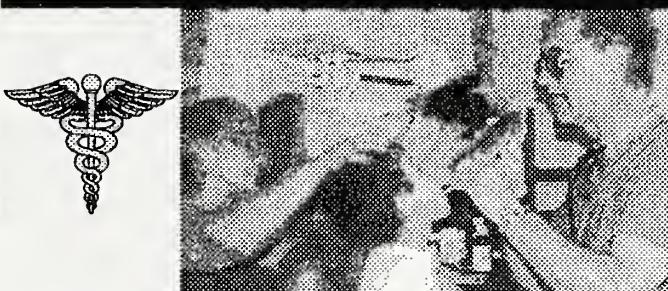
- Volunteer to serve on a task force to revise the current guidelines. The initial meeting will be held in January.
- Host a meeting in your part of the state to examine the issues. Members of the task force will attend and bring your concerns and perspectives to the revision process.

- Volunteer to be a reactor to drafts of the revised guidelines.
- Call or write with the issues you would like to see included in the Guidelines review.

For a copy of the current guidelines and to be a part of their revision, contact Bill Pierson at 303-930-0418.

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Hiring a Medical Practice Consultant®

by Aynah Askanas, J.D.*

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Most physicians hire accountants to deal with their tax issues and financial advisers to handle their investments. Yet many don't recognize that they might need help in deciphering and dealing with changes brought on by managed care and health system reforms. Plenty of consultants are willing to help, but hiring the right one requires knowledge and education on the physician's part.

Medical practice consultants include professionals who have developed expertise in such specific medical office problems as billing and collection, analyzing and negotiating managed care arrangements, appraising the value of a practice, and developing computer systems. They also might be lawyers and accountants who focus on serving physicians and medical groups.

Consultants educate physicians and staff on changes that need to take place and why. Then, they assist the physician in getting the job done.

Before hiring a consultant

Physicians should call in a consultant whenever they and their staff must deal with an important practice issue beyond their own expertise. A consultant is most beneficial when he or she is involved at the earliest stages of a negotiation or project. Before retaining outside advice, however, physicians must clearly identify their goals. For example, when seeking an attorney to create a physician-hospital organization, a physician network, an individual practice association, or some other entity, physicians first must determine what their needs are and what they hope to accomplish by creating a new entity. In a multi-physician practice, the physicians should outline their individual concerns and group goals. Open discussion prompts thoughtful evaluation and might reveal differing expectations. The group should write down all of its concerns and objectives, which will help move all parties in the

same direction and make it easier to evaluate the project's progress and results later. Physicians need to articulate what they want and should compile any necessary documentation before the consultant's clock starts running.

Finding the right consultant

When seeking a consultant, ask other practice administrators, physicians, and state and county medical society staff who they recommend and why. Examine the consultants' credentials, resumes, and experience to see if they mesh with your particular practice needs. Many lawyers and accountants have never handled physicians' business matters. The accountant who does great work on your personal taxes, for example, might have no background in determining an adequate capitation rate. Likewise, the lawyer who did a superb job drafting your will might never have seen an integrated delivery system contract.

After identifying top candidates, physicians should set up appointments to interview them in person. Most consultants will provide at least a half-hour courtesy consultation or take physicians to lunch to discuss the services they provide. Be prepared with the following list of questions:

- What is the consultant's specific experience in handling similar jobs for other physicians or groups? Can the consultant provide at least three references for whom he or she has performed the same or similar tasks? A good consultant has a successful track record with many different medical practices.

(Continued from preceding page)

- Is there a potential for conflict of interest? For example, is the consultant working for a competing medical group? Generally speaking, who are the consultant's clients? Hospitals? HMOs? What percentage of the clients are physicians?

Don't rely on the advice of a consultant retained by the other party in a deal. For example, in any type of hospital-physician arrangement, even where the whole medical staff is involved, the medical staff should have its own legal counsel independent of the hospital's attorney. Individual physicians who are weighing whether to participate in the venture also need to analyze how the arrangement will affect them personally and thus need counsel separate from that of the hospital and medical staff.

- What is the consultant's recommended approach to your practice problem and/or objective?
- What is the consultant's billing rate, and can he or she estimate how long the project will take? Would the consultant agree to complete the project for a set fee?
- When can the consultant start?
- Will the consultant perform the job personally, or will a lower-level associate tackle the bulk of the work? If the latter, ask to interview the associate and see his or her resume and list of references.

Ask for a written proposal

Physicians should narrow the field of candidates to no more than five and ask those finalists to submit formal proposals based on the assignment's description. The proposal should reiterate the assignment as the consultant understands it and provide time and cost estimates, identifying variables that could affect estimates. Indirect costs, such as the level of participation the consultant will need from the physicians and staff, also should be clearly defined at the proposal stage.

The proposal should be clear, concise, and comprehensive, fully and completely stating the services to be performed, the "products" to be

created (if any), the time lines involved, and all costs the physician will incur. If the consultant is chosen, the terms of the proposal should be incorporated into a contract between the parties, discussed below.

Physicians might wish to send out a "request for proposals" to several consultants who have the relevant expertise. The request is simply a letter that tells consultants what type of task you need done and asks them to submit information on whether they can do the job and how much they would charge.

Check those references

Call at least three references, especially those who have hired the consultant for the same or a similar task. Find out:

- Would the reference use the consultant again?
- What was the nature of the consultant's task?
- What did the reference like and dislike about the consultant?
- Did the consultant get the job done to the reference's satisfaction?
- Did the consultant take too long? Did he or she recommend further projects that weren't really necessary? Did the consultant try to sell the reference something that he or she didn't need or want? Did the consultant spend enough time on the project?
- Did the consultant exceed his or her initial fee or time estimate? If so, by how much and why?
- Does the reference recommend the consultant for the specific job?
- Was the consultant accessible, and did he or she respond promptly?
- Does the reference know of other medical practices that have used the consultant? (This will lead you to other references beyond those provided by the consultant.)
- Was the consultant available for issues that arose after he or she was paid?

What will it cost?

It is important to agree on how much the services will cost before the consultant begins. Obtain a written fee agreement. Your contract should

require the consultant to advise you if and as soon as it seems likely that he or she will exceed the cost estimate.

When it comes to hiring a good consultant, physicians should not be penny-wise and pound-foolish. The amount and quality of training, experience, and knowledge that competent advisors bring to a problem inevitably are reflected in the fees they charge. Considering all that is at stake, physicians should view the cost of a consultant as a long-term investment.

A high hourly fee might be balanced by a lower time estimate. Physicians should recognize that the time a project takes can vary with experience. Good consultants with extensive experience orient you and themselves quickly and zero in on issues and alternatives. You do not have to pay for them to reinvent the wheel, and they cost you less in the long run.

It is essential, however, to understand exactly what costs will be involved in a project and what will be covered. Consultants usually structure their fees on an hourly or daily rate, multiplied by the number of hours or days the project is expected to take. Some request a retainer or an advance payment. Some attorneys take litigation matters on a contingency-fee basis, which means their fee will be a specified percentage of the client's judgment, if the client wins the case.

Although currently used by only a small percentage of consultants, value billing--or billing by the job--is increasing in popularity. Value billing is payment for a result rather than for the hours or days it takes the consultant to do the job. Certain kinds of projects, such as educational seminars, are suited to by-the-job billing, and for those jobs physicians might consider negotiating a flat rate.

Most attorneys and accountants use a time-unit system to record billable hours. Generally speaking, the smaller the unit of time used for billing, the lower the client's bill. For example, if a law firm bills in 15-

(Continued)

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minute increments and an attorney spends 16 minutes on a project, the client can be billed for 30 minutes of work. If a 6-minute increment is used, however, 16 minutes of work will be billed as only 18 minutes.

Within firms, often a senior consultant bills at one level, while a lower-level consultant bills at a lower rate. Find out what aspects of a job can be done by lower-cost associates and determine whether you are comfortable using such associates.

Establishing a cost ceiling is an item worth negotiating, especially once both parties have agreed to the parameters of the assignment. If a consultant or attorney is unwilling to set a ceiling, ask why.

Find out if the consultant bills monthly, at the project's completion, or according to some other schedule. Consider linking interim payments to completion of certain project stages or submission of periodic progress reports because such an arrangement encourages the consultant to stay on schedule and provides physicians opportunities to periodically review progress. Also, both parties will have a better chance of identifying snags or misunderstandings as they occur.

Consultants often bill separately for in-house services such as copying or fax transmittal and for out-of-pocket costs such as long-distance telephone calls and travel. You might negotiate to limit the services that you pay for or to lower the cost of those services. You might also try to disallow hourly charges for travel time, or, as a fallback, ask that there be no charge or a reduced charge when the consultant travels after business hours or combines the trip with work for another client. Physicians should ask the consultant to propose an expense budget in writing for their approval. The contract should state how expenses are to be documented.

Working with a consultant

As mentioned previously, develop a

clear idea of what you or your group want to achieve, and put together the relevant background material before the consultant's clock starts running.

No matter how competent, no consultant can perform optimally without full cooperation from the principals in the practice. Be straight with your consultant. Good information is the foundation for good consulting work and representation, and hidden agendas only hamper a consultant's effectiveness.

In many cases, consultants also need cooperation from the physician's office staff to accomplish an assignment. Calling in a consultant, however, sometimes signals change, which your staff could fear or resent. Inform staff of what you hope to accomplish and emphasize that everyone in the practice is expected to support the goals.

Defined and streamlined channels of communication contribute to a productive relationship. In any multi-physician practice, one physician should be assigned to work with the consultant, just as the physicians will desire to work primarily with one consultant.

Consultants need management, too. Make sure they adhere to established time lines, and regularly check that billings are in line with original estimates. Address any problems immediately.

Don't skip over the details

Get everything in writing from your consultant before he or she begins work. Under California law, agreements with attorneys for services in excess of \$1,000 must be in writing. Do not rely on oral promises. In many contracts written by attorneys for their consultant clients, only the terms included in the pages of the contract, or specifically incorporated into the contract, are binding. Therefore, any other representation or promise made in a prior discussion or correspondence might not be enforceable.

Try to negotiate an agreement written with the physicians' interests in mind. If the consultant insists on using his or her own contract,

review it carefully, and negotiate to change language that does not suit you or your project. (Changes can be made in ink and initialed and dated by both parties.) If the project involves a significant financial commitment, have an attorney experienced in physician business matters review the contract. Make sure your independent contractor's social security number or other taxpayer identification number appears clearly on the contract. If the contractor does not give you that number, you are required to withhold 20 percent of his or her payment for taxes. If you don't and are audited, you automatically will be charged 20 percent of your consultant's compensation. You must complete an IRS 1099-M form for consultants each year in which you issued payment to them, whether or not the project is finished.

Resources for physicians

Remember, plenty of help is available to help you find the right consultants. Your state and county medical societies can help steer you toward experienced consultants and provide sample forms.

Ed. Note: The Colorado Medical Society (CMS) maintains a list of consultants who have been screened through the AMA Doctors Advisory Network. You can obtain a copy of this list by calling Lorraine Heth, Division of Health Care Policy, at (303) 930-0409, or you can obtain more detailed information by calling the **Doctors Advisory Network** at 800-AMA-1066, press 2.

* Ms. Askanas is a CMA attorney.

Current CMS Activities

For the past couple of years CMS has been working closely with the Colorado HMO Association (CHMOA). The first project was the **White Paper on Physician Affiliation and Disaffiliation** which was successfully completed a year ago. The White Paper was a collaborative effort between the organizations to inject fairness into the process of HMO affiliation and disaffiliation decisions. The White Paper is currently being implemented by a number of Colorado HMOs.

Since completion of the White Paper, representatives of CMS and the CHMOA have continued to meet and the group has become known as the **CMS/CHMOA Joint Committee**. The committee's mission is to enhance communication between Colorado HMOs and CMS. It shall also be used as a forum to discuss issues of mutual concern, to improve communication between Colorado HMOs and CMS, to increase collaborative efforts between the organizations and to facilitate implementation of the White Paper on Physician Affiliation and Disaffiliation.

CMS also has created a **Managed Care Task Force**. The charge of the task force is to 1) review issues and concerns of CMS members regarding managed care; 2) initiate topics it deems appropriate to be referred to the CMS/CHMOA Joint Committee for consideration and act as a resource for the Joint Committee if requested; and 3) make recommendations to the CMS Health Affairs Council and Board of Directors to modify CMS Managed Care policy as needed.

Finally, CMS was responsible for the creation of the **Colorado Physician Network (CPN)**. The partnership between CPN and Rocky Mountain HMO, which is currently under development, is intended to be a physician and patient friendly health plan available throughout Colorado.



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We need your input

Managed care is clearly one of the biggest issues facing physicians today. The Colorado Medical Society wants very much to assist physicians in the managed care arena, but in order to do that most effectively we need your input. Following is a description of potential products and services we are considering offering to our members. On the reverse side of this page is a summary of CMS current managed care activities. Please take a moment to read this information and then complete the attached card and drop it in the mail to us so we can hear what you think.

Potential Products and Services

CMS is considering offering the following products and services:

1) Contract Review Service

CMS is considering negotiating a discounted rate for its members with one or more law firms to provide a contract review service.

2) Physician's Managed Care Manual

Topics discussed would include: financial incentives, insolvent plans, contract amendment negotiation, risk-sharing arrangements, capitation issues for specialists, verification of coverage, what to do when necessary care is denied, point-of-service plans, termination without cause and more...

What you should know about a plan before signing

How can you determine whether a capitated payment will be adequate?

Will your risk-sharing arrangement put you at too much risk?

3) Model Managed Care Contract

What language should go into your managed care contract? Is a health plan's contract problematic? This model contract would provide you with a "standard" to which you could compare a contract you are considering signing. Topics covered include: capitation provisions, termination provisions, fee for service provisions, risk withhold provisions, and hold harmless clauses.

4) Manuals on physician employment contracts and hospital-based physician contracts

For Current CMS managed care activities see reverse side.

Please complete the following information and mail this card back to us

How likely would you be to use the following products and services described above? Please circle one.

- 1) A contract review service provided by a CMS endorsed law firm for a reasonable fee (negotiated rate for CMS members)?
Not Likely Somewhat Likely Very Likely
- 2) A Physician's Managed Care Manual purchased for a reasonable cost?
Not Likely Somewhat Likely Very Likely
- 3) A Managed Care Model Contract purchased for a reasonable cost?
Not Likely Somewhat Likely Very Likely
- 4) Manual on physician employment contracts purchased for a reasonable cost?
Not Likely Somewhat Likely Very Likely
- 5) Manual on hospital-based physician contracts purchased for a reasonable cost?
Not Likely Somewhat Likely Very Likely
- 6) Comments: _____

Please identify the following:

Your Specialty: _____

City in which you practice _____



John L. Lightburn, MD, Historian
Colorado Medical Society

Learning the Lessons of History

Last month in this section, we wrote about **Dr. Hubert Work**, the 25th President of the Colorado Medical Society and printed the presidential address which he presented at the end of the 25th annual session. In that address, he paid tribute to the founders of the Society and to its first 24 presidents. He reviewed the great advances in medicine, general surgery and gynecology. And then he warned of the dangers of "specialism" in which "the limited field of observation open to those who restrict to a few organs necessarily narrows the scope of vision to a degree impossible to surmount, if adopted as the initial step of practice." With eloquence he urged that all specialties have a strong foundation in general medicine. Dr. Work's remarks were somewhat prophetic for today's practice of medicine as we attempt to define the role and relationship of specialists and primary care providers.

Dr. Work presented his address on the last day of the three day annual session that was convened in the "Ladies Ordinary" of the Windsor Hotel at 18th and Larimer streets. In his address, Dr. Work pointed with pride to the large number of scientific papers presented during the three days of that annual session. According to the minutes of the session, 53 papers were presented by members of the society in addition to two presentations by guest speakers from Illinois. This is an

impressive number of papers when you consider that the total membership of the society was 227. Here is just a sampling of those papers:

- The Relationship Existing Between the Eye and Diseases of the Brain" by Dr. Robert F. LeMond of Denver
- "Inflammation of the Middle Ear with Involvement of the Mastoid" by Dr. William C. Bane of Denver
- "Laryngeal Irritation" by Dr. F.P. Gildea of Colorado Springs
- "Angio-neurotic Oedema of the Ocular Conjunctiva" by Dr. G.M. Black of Denver with discussion by Dr. Edward Adams of Kansas City.
- "Blepharoplasty by Thiersch Grafting" by Dr. John M. Foster of Denver.
- The Diagnosis and Principles of Treatment of Hip Joint Disease" by Professor John Ridlon of Chicago. This was discussed by Drs. Grant, Packard, Freeman and Whitehead.
- "Treatment of Lateral Curvature of the Spine" by Dr. George B. Packard of Denver.
- "The Surgery of Mines" by Dr. R.W. Corwin of Pueblo
- "Favorable Results from Koch's Tuberculin in other than Pulmonary Tuberculosis" by Charles Denison of Denver
- "Is Bicycle Riding a cause of Impotency?" by John T. Davison of Denver and discussed by Drs. Lee Kahn and Leonard Freeman
- "The Nervous and Mental Derangements of Young Women" by Professor Frank P. Norbury of Jacksonville, Illinois.

"With eloquence he urged that all specialties have a strong foundation in general medicine. Dr. Work's remarks were somewhat prophetic for today's practice of medicine as we attempt to define the role and relationship of specialists and primary care providers."

Professor Norbury was then elected as honorary member of the society.

- "Epilepsy: Its Cause and Treatment" by E.R. Thombs of Pueblo and discussed by Drs. Eskridge,



Denver Homeopathic College and Hospital, 1898-1909. Park Avenue at Humboldt Street. (Photo Univ. of Denver)

Wilson and Burns.

- "Castration, the Remedy for Crime" by Dr. B.A. Arboqast of Breckenridge
- "Asexualization for the Limitation of Disease and the Prevention and Punishment of Crime" by E. Stuver of Bawlins, Wyoming. These two papers were discussed by Drs. Blaine, Stoddard and Davison.
- "Abdominoscopy in Obstetrics" by Dr. T.M. Burns of Denver. A symposium of "The Extinction of Communicable Diseases" included an address by Victor C. Vaughn of Ann Arbor, Michigan and papers on tuberculosis, scarlet fever, diphtheria, typhoid fever and surgical infective diseases. Indeed, tuberculosis was a subject of numerous papers during the three days of the session.

As we reviewed the list of papers presented, we were impressed with the dedication, earnestness and ingenuity of these early physicians.

In addition to the scientific papers, the society addressed a number of interesting and important social, economic, political and organizational issues. Dr. John Hall of Denver noted that "the New York Life Insurance Company had decided to cut the customary examination fee from \$5 to \$3" and offered a resolution "that, in the name of all

reputable physicians, we protest against this reduction and wish to place on record our belief that no physician can afford to assume the responsibility of this work at the proposed figures...and that we will give our united efforts to the support to those companies who appreciate honest and conscientious medical examiners and reward them accordingly". So early in its existence, the society became an advocate for

physicians in their relationship with insurance companies. What would Dr. Hall have to say now?

Dr. Henry Sewall of the Sanitation and Preventive Medicine committee reported on an "Inquiry into the condition of tuberculosis in Colorado". He expressed concern over the false assumption by many Coloradans, including some physicians, that the benefits of the favorable climate in Colorado protected the native population from contracting tuberculosis from the many persons with active tuberculosis who were flocking to Colorado in search of a cure.

In an effort to collect data on the status of the disease in the state, he sent out 400 questionnaires to all the physicians in the state to get information on the number of cases of "phthisis, consumption or tuberculosis." To these 400 inquiries, he received only 39 replies. No records of births and deaths had been kept prior to 1891 and in 1895, there were no official records kept in Leadville, Cañon City, Trinidad, Fort Collins or

Greeley. Dr. Sewall asked the Society to urge all physicians to keep adequate records of births and deaths.

A year prior to this meeting, then President Edmmund J.A. Rogers in his address to the society had suggested that better laws for the regulation of the practice of medicine be enacted and that the three medical schools in Denver be consolidated. A committee was appointed to accomplish this task. Legislation was drafted and introduced to the legislature but failed to pass. Apparently many physicians were concerned that a state board of medical examiners would be dominated by graduates of one school to the disadvantage of the other schools. In addition to the three medical schools, there was also three medical societies (Regular, Homeopathic and Eclectic) and two additional schools: homeopathic and osteopathic. The legislature would not touch the issue with a ten foot pole until physicians arrived at some position of unanimity among their own profession. The committee was instructed to continue their efforts to bring about a law that would protect



Bolles Institute of Osteopathy, 1901-1904. 1457-59 Ogden Street. (Photo courtesy C. Robert Starks, D.O.)

the state from the "quacks, charlatans and vandals."

It was moved and passed the American Neurological Association be invited to meet in Denver in June of 1897.

Other less momentous issues were also discussed and finally the assembled member elected officers for 1895-96 naming, Isaac B. Perkins as the 26th President. There will be more about this interesting man in the next issue of *Colorado Medicine*.

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AMA UPDATE

Richert. E. Quinn M.D.

*Senior Colorado Delegate to the
American Medical Association*



At the American Medical Association (AMA) Interim Meeting in Washington, D.C. (Dec. 3-6, 95), the House of Delegates debated over 40 reports from the Board of Trustees and the AMA Councils, and more than 150 resolutions submitted for the meeting from the various reference committees and the floor of the House.

Several of the more important areas of discussion and action follow:

The results of Congressional efforts toward budget reduction and Medicare reform are currently pending, but there can be no doubt that the AMA has been extremely influential in the debate thus far. Malpractice reform, antitrust relief, CLIA (Clinical Laboratory Improvement Act of 1988) regulation relief, and "Stark" provisions have all been "on the table". A pluralistic approach to Medicare, including an emphasis on patient choice of provider and incorporating traditional fee for service, managed care, and medical savings accounts, is likely to be implemented. The expected cuts in reimbursement for physicians have been greatly modified, especially in primary care. The Republican plan included far more input from organized medicine than the "Clinton" plan of a year ago. If you support the AMA with your dollars, it appears you certainly got your money's worth this year.

Many of the resolutions and reports focused on various aspects of managed care. The Association has not endorsed a mandatory "point of service" provision, although it is strongly endorsed by some of the specialty societies. Physician guidelines vis-a-vis managed care organizations are evolving with a final report due in six months. The AMA does endorse a "mandated option" approach for employers, wherein various types of plans are required to be offered to employees.

In organizational news, the AMA is undergoing a massive restructuring in order to be more inclusive to a broader range of physicians. Specialty, mode of

practice, gender, ethnicity, and geographic location are all to be considered in representation. Initially, increased specialty representation in the House of Delegates is anticipated. The structure and function of the Board of Trustees is also to be analyzed. Expect much more action on this front.

Here, I want to brag a little bit about our Colorado doctors' role in the AMA. Dr. Richard Allen, chairman of the CMS Legislative Council and alternate delegate for the American College of Obstetrics and Gynecology was elected to the AMA Council on Medical Education at this meeting. Last summer I was elected to the Council on Constitution and Bylaws. Dr. Joel Karlin was appointed to the Council on Legislation last spring. Dr. Rob Bogin has been an AMPAC board member for a couple of years.

For a state with only three delegates, three alternate delegates, and 2 specialty society representatives who participate with our delegation, Colorado is extraordinarily well represented in the AMA hierarchy. We set out on the campaign trail with this objective in mind several years ago. With the very generous support of the CMS Board of Directors and CMS membership, as well as the tireless efforts of Sandi Maloney and her staff, we are well-postured at a time when the AMA is experiencing a resurgence as judged by its recent political successes and by its restructuring effort.



HIV Information

Philip R. Lee, MD, Assistant Secretary for Health for the US Department of Health and Human Services has released public information materials to help pregnant women who have HIV to make informed decisions about medical interventions to reduce the chances of perinatal transmission of the virus.

In the United States alone, about 7,000 infants are born each year to HIV positive women. As many as 2,000 of these infants will acquire the virus *in utero*, during childbirth or through breastfeeding. AIDS is the seventh leading cause of death in children 1-4 years of age and the fourth leading cause of death among women 25-44 years of age.

The new consumer information translates into lay language the results of a National Institutes of Health clinical trial known as the AIDS Clinical Trial Group (ACTG) 076, which showed that zidovudine reduced the rate of perinatal transmission of HIV by two thirds.

Cancer Registry Changes

In an effort to assure complete reporting of cancer in Colorado, the Colorado Central Cancer Registry has expanded its list of reporting entities to include "physicians who do not refer cancer patients to any other facility for diagnosis and/or treatment". This was added to the existing reporting list of hospitals, diagnostic and/or treatment clinics, and pathology laboratories.

Reporting of all Colorado cancer patients to the Colorado Department of Public Health and Environment is required. These reports should include the name and address of the patient, medical history, environmental factors, date and method of diagnosis, primary site, stage of disease, tissue diagnosis, laboratory data, methods of treatment and physician names and be submitted no later than six months from diagnosis date.



Lawmaker honored at "Fish Fry"

Former legislator and long-time children and family advocate Marleen Fish will be honored at the Arvada Center on February 14. In an announcement promoting the bi-partisan dinner, Jefferson County Sheriff Ron Beckham and District Attorney Dave Thomas credited Ms. Fish with the organization and early success of JeffCo Build A Generation, a substance abuse and gang activity prevention organization.

Some 4-500 people are expected to roast the former Representative at the Fish Fry, which is underwritten by corporate sponsors and will benefit Build A Generation. Sponsorships for tables or individual tickets are still available. Call Kelly at 303-742-9466 for more information.

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MEN'S SPECIALTY CLINIC is searching for a physician in a Denver suburban practice. IM, FP, or general medicine background with office experience preferred. No call, no evenings, no weekends required. 15-20 patients per day. Need to be an excellent communicator and able to relate to patients extremely well. Generous compensation and benefits package. Send CV to Chuck Branson, IMR, 8326 Melrose Drive, Lenexa, KS. 66214 or Fax to (913) 894-0549. Call 1-800-772-8168 Ext. 543. 01/0196

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Once your selection is firm, your purchase or lease will be arranged at **prices normally available only to large corporate fleets.**

Colorado Medical Society has endorsed Rocky Mountain Fleet Associates as a CMS member service, based on the satisfaction of the many physicians who have used their services over the past several years. These physicians have reported excellent results, **usually with savings of more than \$1000 from even the best negotiated showroom price.**

For more details, call **(800) 864-4388.** In Denver, **753-0440.**

Colorado Medical Society

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06/1195



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

*There is a tide in the affairs of man
which taken at the flood leads on to fortune;
Omitted, all the voyage of their life
is bound in the shallows and in miseries
On such a full sea are we now afloat,
and we must take the current when it serves,
or lose our ventures.*

—William Shakespeare, *Julius Caesar*

On an odd occasion, I was sitting at home the other night, thinking about the world and whether it is still basically round.... since I was last out exploring. These days, you never know whether the last spot on the globe you touched is even still in existence.

I had just received in the mail a travel brochure about some far-off place and I got to I remember now what it was It was Stratford Upon Avon; and now I remember why I headed this piece with the excerpt from *Julius Caesar*.

Anyway, I was thinking about how important it is for each of us to sample as many diverse cultures in a lifetime as possible, because with each new exposure our own lives become enriched many times over. I received so many bonuses from Stratford: the aura of the bard; the feeling of standing in such an historically significant spot; feeling the tingling sensation of how much this man (or at least the purported efforts of this man) has influenced recent history.

What Will said (*There is a tide..*) is absolute; it is typical of a "natural law". For every person there comes a time when, if the events of that time are analyzed and acted upon, that life will be forever influenced and the time and tide will carry the person forward to (good) fortune. Some people are fortunate early on: opportunity comes, but many don't recognize it and miss out. However, natural law most often dictates that they get another chance at the prize.

It seems to me the practice of medicine is at one of those times: it's as though the tide is rolling against the medical professional, and this may be the time it is "*at the flood*", the time when someone must **carefully analyze the events and take advantage of the circumstances**. Reverse the tide. It can be done and here are some very positive examples:

Flood: widely divergent standards of medical care and charges for said care in Colorado.

Response: Creation of the Colorado Foundation for Medical Care and the eventual federally-authorized Professional Standards Review

Organization (PSRO).

Flood: Colorado Medical Society membership awash in a medical liability crisis and rapidly rising insurance costs controlled by out of state non-doctors.

Response: Create a physician-owned and operated professional liability company and turn the tide, keeping millions (and millions) of dollars in Colorado working for Colorado physicians.

Flood: Medical practice losing ground and patients to HMOs, managed care and managed services organizations with the multiplication of insurance plans and restrictive practice modalities or limitation from physician panels.

Response: Formation of the Colorado Physician Network, a statewide organization which becomes a statewide physicians' agent contracting with a single HMO.

These are a few of the major reactions to the tides in the (recent) affairs of medical practice. There were other such smaller victories.

Yes, today, medicine may be at its highest flood level ever, but the tide can be turned. In each of the three incidents cited above there was seemingly a single common enemy, and the physicians reacted as one and "took the flood". Each of these adversities, when challenged and turned to the physician's advantage, contributed to improved medical care in general.

Do as you have done before: turn adversity into asset; reverse the tide toward your good fortune. There are things you and your peers (and CMS) can do together.

So Who's Got Money To Burn These Days.

American businesses watched 22 billion dollars in unpaid receivables go up in smoke last year. How much money are you letting vanish into thin air?

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LEGAL UPDATE

Are You Protected as an Officer or Director?

While outside directors of corporations are blessed with special opportunities for business development and community service, that blessing comes with the potential cost of being named in a lawsuit when shareholders are dissatisfied with the company's performance and seek to recoup their losses through allegations of corporate mismanagement.

Directors are generally shielded from liability for decisions made in the good-faith exercise of their business judgement, and in exercising that business judgement they are entitled to rely on the opinions of experts, the factual representations of company employees, and on the work of subcommittees of other corporate directors. In addition, Colorado's corporate code expressly absolves an

officer or director of liability for any "injury to person or property arising out of a tort committed by an employee unless such director or officer was personally involved in the situation giving rise to the litigation."

Corporations also have the power to provide for the legal defense and indemnification of directors in the event they are sued for actions arising out of their service to the corporation, and in some cases the corporation is required to provide a legal defense and indemnification. That protection is enhanced when the directors are protected through an "E&O" insurance policy that provides coverage for the defense and indemnification of the director.

For those business people who serve as outside directors or managers

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

of corporations or LLCs, it takes but a small investment of time to review the documents necessary to determine the extent to which they are protected, as well as the extent to which such protection is supported by appropriate insurance coverage. As any corporate director will attest, it is easiest to keep your eye on business when you do not have to look over your shoulder to see if some potential liability is sneaking up on you.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

Call for Nominations

The Physician Award for Community Service, sponsored by Wyeth-Ayerst Laboratories, is designed to provide recognition to men and women who are actively engaged in the practice of medicine for the many and varied services above and beyond the call of duty which they render to their respective communities. The award was established in 1961 in appreciation for the time and personal sacrifice devoted by physicians to the welfare of their communities.

The Colorado Medical Society is now taking nominations for this award to be presented at the annual meeting in September. Nominees must meet the following criteria:

- 1) The nominee must be a licensed Colorado physician;
- 2) The nominee must be living; no posthumous awards are permitted;
- 3) The nominee must not have received this award previously;
- 4) The nominee must have compiled an outstanding record of community service.

Please help to promote the image of the medical profession in its ongoing efforts to be a positive participant in community life. Nominate a colleague today! Please call 779-5455 Ext. 2425 or 1-800-654-5643 for more details.

Dear Physician,

In the coming weeks you will receive an update form letter for the Colorado Medical Society Medical Office Resource Book.

The Medical Office Resource Book is an invaluable reference tool, and it is important to all of us here at CMS that your correct information be displayed.

Some questions that you can expect include:

- name
- addresses and telephone numbers (office and home)
- fax numbers (office and home)
- specialty practice
- foreign language(s) spoken in your offices

The directory update letter will be arriving in late February and it is critical that you return it as soon as possible. Current directory information will be displayed unless updated versions are received by March 15, 1996. This year's Medical Office Resource Book will be even bigger and better than years before. Of course CMS encourages any comments or suggestions on how the Resource Book can be made better. If you have any ideas please call 779-5455 Ext. 2425 or 1-800-654-5653.

Thank you for your prompt cooperation.

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

New Legislative Changes to Prescription Practices Averted

SB 79, *Concerning Requirements for Processing Prescriptions*, was introduced by Sen. Frank Weddig into the 1996 General Assembly in January. The bill would have placed several requirements on physicians when prescribing. The bill would have:

- Required that a prescription be mechanically produced, printed or computer generated and then be signed by the physician. Handwritten prescriptions would no longer be allowed;
- Required that diagnosis or symptoms for which the medication or device was prescribed be on both the label and prescription so that patients could identify and distinguish one prescription from another.

The Colorado Medical Society (CMS) opposed this bill. After meeting with Sen. Weddig, it was agreed that the bill would be dropped if CMS would communicate the concerns that prompted the legislation to its members.

Physicians, please be aware of these concerns. It is believed that occasionally pharmacists are unable to read handwritten prescriptions, which increases the possibility that a prescription might be filled inaccurately. Some patients with numerous prescriptions have trouble distinguishing one prescription from another.

Rep. Moellenberg Dies

State Rep. Roland Dean "Bud" Moellenberg died January 28, 1996 after suffering a heart attack.

Moellenberg, 59, was a farmer and rancher serving his third term in the Colorado legislature. Rep. Moellenberg was well known among members of CMS for his steadfast support of rural health issues.

Most recently he was the sponsor of the CMS Rural Health Bill (HB1073). The bill would authorize repayment of student loans for physicians, physician assistants and advanced practice nurses who agreed to practice in rural areas. It would also establish income tax credits for persons engaged in rural health care delivery. A new sponsor for the bill is currently being sought.

CMS will miss Rep. Bud Moellenberg's legislative leadership.

AMA Membership Drive

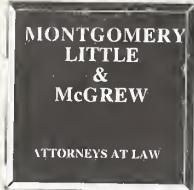
In early February, AMA recruitment letters will be mailed to CMS members that did not join AMA in 1995, or have not renewed their 1996 AMA membership.

The letter is being sent under CMS cover because membership processing is a paid service by the AMA.

"Art and History" to highlight Women In Medicine meeting

Dr. Henry N. Claman, MD, Distinguished Professor of Medicine and Immunology at the University of Colorado Health Sciences Center, is also a serious scholar in art and music. Dr. Claman is well known for his instructive and entertaining presentations.

At the March 22 Women In Medicine Business meeting to be held in conjunction with the CM Interim Meeting, Dr. Claman will present an illustrated lecture on "Art and History".



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

New Twist to the "Knowing Concealment" Exception to the Medical Malpractice Statute of Limitations

General Rule: Medical malpractice claims must be filed within two years after the patient discovers, or should have discovered, the injury and its cause, or at the latest within three years after the negligent care was provided. Claims filed after the limitation period has expired are time barred.

If only it were so easy. Although the general rule seems simple enough, there are so many exceptions that the determination of whether a limitation period has expired is seldom clear-cut. The rule itself allows for disagreement on the question of when the commencement date on the time the patient "discovers" the injury and its cause. In some cases the date of discovery is as obvious as the claim itself; for example, when a patient wakes up to find that the right knee joint has been replaced instead of the left, the patient's claim accrues, and the limitation period begins to run, on the day of surgery.

In other cases the date of discovery is far less apparent, and in some cases discovery alone will not trigger the running of the limitation period.

Exceptions which extend the limitation period include minority of the patient; disability or incapacity of the patient; the existence of a continuing physician-patient relationship during which the negligence occurs; misdiagnosis, or other act or omission, by the physician such that the patient did not know and could not have known of the physical injury and its cause; leaving a foreign object in the body of the patient; and knowing concealment by the physician (or other health care provider) of the commission of a negligent act or omission.

The final exception for knowing concealment is the subject of a recent Colorado Supreme Court opinion.

The knowing concealment exception, which has been a part of the statute of limitations since 1977, is based upon the concept that a wrongdoer should not be able to take advantage of his or her own wrong. It prevents physicians from benefiting from their own efforts to hinder the patient's discovery of the negligence claim against the physician.

Here are the pertinent facts in the case recently decided: A surgeon removed a patient's gallbladder. Cholangiograms taken during and after surgery established that the surgeon's probe of the common duct caused a perforation. Also, the official radiographic interpretation of the cholangiograms indicated that a leak from the common duct developed during surgery.

The patient's condition deteriorated in the days and weeks following surgery. The surgeon met with the patient several weeks after surgery and told her she had a hole in her common duct caused by a gallstone. She was admitted to the hospital for additional surgery to repair the puncture.

More than three years later the patient learned that the hole in her common duct had been caused by the gallbladder surgery, not by a gallstone. When she sued the surgeon more than five years after the surgery, he claimed that the statute of limitations had expired and that her claims were therefore time-barred. The surgeon argued that the knowing concealment exception to the medical malpractice statute of limitations only applies if the patient suspects negligence, confronts her physician, and then is misled by the physician. The trial court agreed and granted summary judgment in the surgeon's favor. Neither the Colorado Court of Appeals, nor the Colorado Supreme Court agree with this analysis of the knowing concealment exception.

The elements which must be proven by the patient in order to take advantage of the knowing concealment exception are:

- 1) the physician knew he or she had committed a negligent act or omission; and
- 2) the physician intentionally made a material misrepresentation or failed to disclose material information that impeded the patient's discovery of that negligence.

This test for determining whether there has been a knowing concealment diverges from prior case law which states that "a knowing concealment occurs when a plaintiff suspects or discovers that a wrong has been committed and is subsequently misled or misinformed by the doctor as to what was done or its effect. There must be a negligent act and a subsequent fraudulent concealment."

The Supreme Court's recent opinion rejects the patient's knowledge or suspicion of negligence as an element necessary to prove the existence of a knowing concealment. Now, the patient need not have known about or suspected negligence prior to the physician's concealment. The state of mind at issue when a

Continued on following page...

knowing concealment is alleged to have taken place, is that of the physician, not the patient.

The knowing concealment exception does not toll the statute of limitations perpetually; rather it extends the statute of limitation until two years after the person bringing the action discovered or in the exercise of reasonable diligence and concern should have discovered the act or omission. Even if negligence is knowingly concealed by the physician, the patient is still under a duty to use ordinary and reasonable diligence and concern to discover the existence of a claim against the physician.

Practice tip: The principles surrounding the knowing concealment exception to the statute of limitations do not suggest that physicians must tell patients each time their medical judgement might differ from the medical judgment of another physician. The exception is limited to those circumstances when the physician *knows* he or she deviated from the standard of care, and the physician intentionally misleads the patient for secondary gain, such as the avoidance of potential legal liability.

24-Hour Drive-Through Delivery Bill Dropped

Rep. Marcy Morrison dropped legislation that would have prevented insurers that offer maternity benefits from sending mothers and their newborn infants home before they are ready.

About 90 percent of the state's largest health insurers agreed to voluntarily implement the length-of-stay standards proposed in HB1015.

The Post-Delivery Care for Mothers and Newborn Infants Act would have required insurers that offer maternity benefits to provide 48 hours of inpatient care for a mother and her infant following a vaginal delivery and 96 hours of inpatient care following a cesarean delivery. Earlier discharge would be allowed only with the mutual consent of the attending physician and the new mother. In the past, insurers have indirectly influenced shorter stays by requiring that physicians get approval from insurance companies if the mother and newborn were going to stay in the hospital more than 24 hours.

Negotiations on Public Health Leadership Begin

Negotiations on the Governor's recent bill which removes the requirement that the Executive Director of the Public Health & Environment Department be a physician have begun. Sandra Maloney will represent CMS in the negotiations with Allen Weil, Executive Director of the Department of Health Care Policy and Finance. HB 1125 was introduced in January. The CMS Board of Directors recently discussed the proposals of this bill during the board meeting on January 12, 1996. Please see this month's edition of *The Lobby* for more information.

Rocky Mountain Village Easter Seal Camp

Volunteer physicians help make summer camp safe and special for children and adults with disabilities. Physicians are needed to help the on-site nursing staff provide professional medical care for campers and staff during their residential summer camping season. **REWARDS ARE MANY!**

In addition to working with a dedicated and motivated staff, actually practicing medicine on occasion, lodging and meals for physicians and their families are provided.

The Colorado Easter Seals Society has operated the Rocky Mountain Village summer camp at Empire Junction in the Clear Creek Valley since 1951. While the camp offers exciting traditional camp activities like fishing, arts and crafts and horseback riding, its location serves as an excellent base for touring local attractions such as Summit County, Rocky Mountain National Park and Georgetown. Volunteer today.

**Call Paula Breeden, RN, Health Care Services Dir.
(303) 892-6063**

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

MGMA/CRAHCA

Physician Services Practice Analysis Software
Hands-on Training and Report Analysis Workshop
February 8-9, 1996
Englewood, Colorado
(303) 397-7876

Colorado Medical Society and other health care organizations

Conference on Domestic Violence
February 9, 1995
Embassy Suites, Stapleton, Denver, Colorado
(303) 393-3292

Division of Workers' Compensation

Level II Physician Accreditation Seminar
February 9-10, 1996
Denver, Colorado

Contact: Faye Boyd, (303) 575-8756

Colorado Healthcare Communicators

The Bermuda Triangle of Health Care
February 15, 1996

Denver, Colorado

Contact: Deb Gillette (303) 832-7471

RSVP by February 12

Colorado Society of Osteopathic Medicine

Advanced Cardiac Life Support Course
February 24-25, 1996

Keystone Lodge & Resort

15 hours AOA Category 1-A CME credit

Contact: Patricia Ellis at (303) 322-1752

American College of Cardiology

Workshop on 2-D and Doppler Echocardiography
February 26-29, 1996

Vail, Colorado

18 Category 1 AMA

(800) 257-4739

Joint Commission on Accreditation of Healthcare Organizations

Breakfast Meeting

February 28, 1996

Denver, Colorado

RSVP: Shelby Kampert at (708) 916-5830 by Feb. 23

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference
February 25-March 1, 1996

Keystone Lodge & Resort

38 hours AOA Category 1-A CME credits; AAFP
prescribed course hours

Contact: Patricia Ellis at 303-322-1752

MGMA/CRAHCA

The Integrated Health Care Puzzle
March 4-6, 1996

Denver, Colorado

(303) 397-7881

CRAHCA

14th Annual CRAHCA Conference: Integrated
Delivery Systems

March 4-6, 1996

Denver, Colorado

(303) 397-7876

American College of Cardiology

The 3rd Annual Echocardiography Workshop at Vail
March 26-29, 1996

Vail, Colorado

Contact: (800) 257-4739

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on
Inner Ear Medicine and Surgery

March 1996, Aspen, Colorado

Contact: Jane Wells or I. Kaufman Arenberg, MD
(303) 778-4235

MGMA/CRAHCA/ACMPE

The Essentials of Group Practice Management

March 25-27, 1996

Denver, Colorado

(303) 397-7876

MGMA/CRAHCA

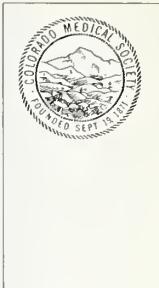
Physician Services Practice Analysis Software Hands-
on Training and Report Analysis Workshop

March 28-29, 1996

Englewood, Colorado

(303) 397-7876





*Joel M. Karlin, MD
President, 1995-1996*

As we approach the 21st century, what is the future for organized medicine? Or is there a future?

The Colorado Medical Society has been more fortunate. We have seen a significant growth in membership recently to an all time high of almost 5,200 members. With somewhere in the range of 7,200-7,500 practicing physicians in our state, CMS represents more than 70% of our docs. We hope this increased membership represents the feelings of fellow physicians: that CMS is addressing the issues of importance to them and their patients. It is my feeling that physicians will join those organizations which best represent their practice mode and economic center. With increased physician consolidation and reorganization of our health care delivery system throughout most of Colorado, it is important that each component in the Federation of medicine examine its own structure and function and determine its relevance to each of its members.

The issue of organizational structure and function has been visited and revisited repeatedly over many years. A little more than a year ago, CMS began discussing these related issues again in our Organizational Study Committee, a group of primarily past CMS presidents and current leadership. In its deliberations, it identified two current groups of underrepresented physicians in CMS, academic and staff/group model HMO physicians. An Organizational Task Force (OTF) with much broader physician representation was then appointed to explore these issues in greater depth. It solicited proposals which would facilitate membership for such physician groups while attempting to

put in place a mechanism of additional physician group representation in the future. Structured proposals were received from Drs. Ron Tegtmeier and Steve Thorsen. The OTF presented a proposal designed to facilitate membership in CMS of more academic physicians at the Annual Meeting of the CMS House of Delegates last September. The House referred the proposal back to the OTF to be considered by a smaller group comprised of OTF members and academic physicians. That group has met, and suggestions will be forthcoming. Additionally, a study has been commissioned by an outside firm to solicit both CMS member and non-member input. The OTF will review these findings along with the proposals received, and make recommendations to the House of Delegates for deliberation.

Concerns about the future of organized medicine are not simply a state issue. Component medical societies have been threatened by the development of Physician-Hospital Organizations (PHOs) and Physician Organizations (POs). In one rural community so affected, the physician leaders recently questioned the continued need for their county medical society.

On the national scene, your American Medical Association has undertaken the Study of the Federation project to find ways to improve the effectiveness of the entire Federation of Medicine. With nominations from individual components of the Federation, including county, state, and specialty societies and the AMA, the Consortium was appointed and met repeatedly over

These are questions that leaders of organized medicine at all levels have been asking more frequently in recent years. Certain events in other parts of the country would make one ask if organized medicine as we know it today is failing to provide a forum for physicians to discuss issues of importance to them. In Nevada, managed care physicians have started a separate state medical society for managed care physicians. In California, the Los Angeles County Medical Society saw a precipitous drop in membership over a two year period in the range of 20-30%. This was a county society of more than 7,000 members at one time. Nationwide, membership in state and county medical societies has leveled off or decreased.

the last year to answer the following questions:

What can be done to make the Federation function more effectively? How can duplication of effort and cost be reduced? How can we coordinate the activities of each component of the Federation better to improve overall advocacy efforts? What could be done to offer to member products and services that are the best value? How would the organizational structure need to be changed to facilitate these functional improvements so that the Federation could act and speak credibly for the whole profession of medicine?

The report from the Consortium was presented to the House of Delegates at the recently completed meeting in December. It consisted of 34 separate recommendations which could be divided into the following broad headings: basic premises and directions; role, relationships, and joint ventures; governance and structure; and, implementation. The main recommendation of the Consortium report was to increase representation of specialty societies and groups representing a physician's mode of practice. Not unlike the recent debate in Congress on term limits, the most contentious issue was the proportionate reduction in state medical society representation (from 79% to 58%) to allow for increased specialty society representation (from 19% to 36%). The recommendations of the Consortium, which were supported by AMA leadership, would have resulted in a House with 535 delegates, up from the current 432 delegates with a target ceiling of 625 delegates in the future. Such a change would have necessitated a reduction in the size of state delegations, in some cases up to 42%. The size of the Colorado delegation would have potentially decreased from 3 to 2 delegates. The House, led in the debate by large state delegations, rejected the proposal for an absolute decrease in the number of state delegates, and deferred decision on a formula for specialty society and "mode of practice" representation to

the June, 1996 meeting after further study.

The House did provide the general direction for a new Federation of Medicine. Its recommendations included:

- each medical association should retain its individual identity and activities, and should function within the framework of the new Federation embodied by the AMA;
- the restructured Federation should be built upon its existing components, but may add additional components;
- individual, not association, membership should continue;
- primary objectives of the new Federation should be an increase in value of membership, and unity of voice and action of all Federation components;
- physicians should be encouraged to participate at all levels. There should be coordination of activities and streamlining of roles to reduce duplicative efforts;
- the role of each organization representing physicians should be clarified to take advantage of strategic positioning;
- the AMA House of Delegates should be as inclusive as possible of physician organizations reflecting the major dimensions of a physician's life;
- the AMA Councils should be analyzed by the Council on Long Range Planning to determine if similar efforts to reflect change should be made;
- the Speaker of the House of Delegates should establish a committee of the House to examine the election process and composition of the AMA Board of Trustees and make recommendations to the House; and
- a smaller group of the Consortium, the Project Team, should make recommendations on implementation of the changes.

It is critical for our AMA to go through this process of reevaluation of purpose and structure. If only 40% of physicians nationwide have become members of AMA, then 60%

of physicians must believe that AMA does not meet their needs. Physicians will join the AMA in greater numbers when they believe that the AMA provides an open forum in which their views can be expressed and openly debated before policy is established, and also demonstrates added "value" in programs and services for the cost of their dues. Similarly, lessons learned in the debate at the AMA should become part of the deliberations at CMS and component societies. I believe that the more united we are at each level, the more effective our voice will be in advocating for our profession, our physicians, and most importantly, the patients we serve.

It is important that each of us have the opportunity to provide input into the proposed organizational changes in organized medicine at all levels. What should we be doing at CMS? at the AMA? Share your thoughts with your component society delegates and leadership. Contact members of your AMA delegation. We need to hear from you to better represent all physicians.

At the CMS House of Delegates Interim Meeting next month, during lunch on Saturday, AMA President, Lonnie Bristow, M.D. will participate in a panel discussion related to how well the AMA represents the viewpoint of each component by the Federation of medicine. Joining Dr. Bristow will be Colorado physician leaders representing differing constituencies and points of view. On Sunday morning, immediately following the meeting of the House, a program entitled, "The State of the Society" will present up to the minute information on important issues being addressed by CMS, including a report from your AMA Delegation. Even if you are not a delegate, you are welcome to attend, and your participation is encouraged.

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*Sandra L. Maloney
Executive Director
Colorado Medical Society*



Mary Lee Johnston has retired . . . again.

She retired the first time when she and I worked for Blue Cross and Blue Shield of Colorado. She started making noises about wanting to spend more time with her family. So she retired and left me behind. A few months later, I came to work for the Colorado Medical Society.

In 1989, I was looking to hire an administrative assistant and Mary Lee was looking for employment. We teamed up again. When I accepted the job as Executive Director at CMS I was certain that there was only one person who could help me through the maze, and that was Mary Lee. So I talked her into becoming my Executive Administrative Assistant. That's been about six years ago, and I can't imagine being able to make it without her. She's been a Mother, a First Sergeant, a constant through all this time.

Probably the most important aspect of her job at CMS was to take over the grievance process. If you're not familiar, that is a patient with a grievance against a doctor, a doctor with a grievance against a patient, a doctor with a grievance against a doctor, or hospital, or other health care provider. It does get sticky.

What this means is that Mary Lee would be the one who received these telephone calls, usually someone bleating about being wronged by the doctor over charges, manner of treatment, bad treatment, unskilled treatment, uncaring attitude, poorly trained staff, who knows what. Mary Lee would listen. . . and listen, and tell the caller where this or that kind of complaint would have to be registered,

whether it would have to go to the Board of Medical Examiners, to a lawyer, to the local component grievance committee, or . . . well, Mary Lee had a way of handling these calls, no matter how grievous.

Mary Lee developed a way of getting right to the cause of the hurt, drawing it out and allowing the caller to feel as though they had had their day in court. It was more like a day in the sun, because so many of these people were looking for attention the felt they didn't get in the doctor's office or presence; possibly they were offended by the offhand response to a question asked of the doctor; maybe it was the way they were treated on the phone by a staff person. Many times that's all it takes to make someone ready to file for malpractice. These people (hundreds of them) no doubt had legitimate complaints, however minor, but because Mary Lee talked to them (in fact, Mary Lee's real talent was the ability to listen in a caring manner) they were soothed and much litigation was avoided.

Mary Lee is a person who can be trusted; she took both the doctor's and the patient's privacy very seriously, no matter how minor the complaint. She did, however, share with me some of the complaints she heard. Of course, I know a lot about her abilities and manner in handling grievance calls because I have never been far from Mary Lee as long as she's worked at CMS. I could overhear a lot of her conversation and the mannerisms.

Through all this, Mary Lee continued to staff the grievance committee and she has realized the



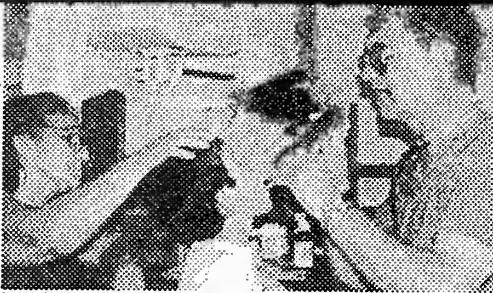
Mary Lee Johnston

importance of trying to resolve these grievances before they reach the stage of arbitration, negotiation or litigation. There is no doubt in my mind that Mary Lee has saved much of all of this from happening, thereby saving frustration, expense and a further breakdown in the doctor-patient relationship.

The grievance process was only one of Mary Lee's assigned tasks. Though it didn't say so in her printed job description, she also served me as "Mom", "1st Sergeant", counselor, shield, and all-round goodbody. She got to making noises again and retired from CMS as of January 12th, as she put it, to go home and "squeeze my grandkids" and "hold and love and cuddle babies". She's mighty good at all that, too. We won't lose her altogether; she'll still be back to handle some special projects . . . the ones she wants to work on. Our main loss is in that important position of preserving good relations between the doctors and the patients . . . that link to civility we can many times maintain only through a grievance process.

Thanks, Mom!

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*Richard Allen, MD, Chairman
Council on Legislation*

The 1996 Colorado Legislative session commenced on January 10 and the Colorado Medical Society Council on Legislation has been hard at work. The Council met on January 17 during an infamous Colorado blizzard. Six dedicated members attended the meeting.

Legislative Report

The Rural Health bill is at the top of the Council's legislative priority list. The bill will be introduced by Rep. Moellenberg with the Council's support and then to the Finance and Appropriations Committee. Once there the Council expects that there will be an amendment to remove the tax credit but not the loan forgiveness.

SB 49, regarding the continued licensing of lay midwives, was scheduled for a hearing during the week of the January 15, but has been withdrawn by the sponsor to be studied for another 30 days. CMS has been working closely with the Colorado Academy of Family Practice (CAFP) to oppose the lay midwifery bill. CMS will also support the CAFP's plans to amend the Pharmacy Practice Act.

Other items on the 1996 Council's agenda include a request from the BME to support a \$5 per biennium increase in licensing fees to hire extra personnel to deal with public grievance issues. The Council is supportive of this measure. However, it will run counter to SB 41 which has been introduced by Sen. Rizzutto to put a cap on all licensing fees of \$150. (Physicians already pay \$150 a year.)

Per the recommendations of our Workers' Compensation Committee,

we will oppose Senate Bill 107. This piece of legislation would establish a doctor/patient relationship with providers conducting independent medical examinations. The BME is also opposing this bill.

The Council has recommended that CMS support HB 1030, which deals with newborn screening. Council member Dr. Joe Jarvis will testify on behalf of HB 1030, which has been introduced by Rep. Tucker and Sen. Wham.

Another newborn issue is the 24-hour drive-through delivery bill (HB 1015 Post-Delivery Care for Mothers and Newborn Infants) sponsored by Rep. Morrison and Sen. Hopper. As of this date, CMS understands that the HMO Coalition is willing to completely administer all the recommendations of this bill in order to avert legislation. All 16 HMO's operating in Colorado have agreed to sign off on this. Legislation is pending until all signatures have been obtained.

The Council is closely watching many other bills, including a proposal from the Hospital Association to form Health Service Districts, a bill from the radiologists regarding Telemedicine, as well as HB 1021 to limit interest payments on malpractice awards of noneconomic damages. HB 1082 introduced by Rep. Friednash, for the Colorado Coalition of Women's Health Care with the support of the Colorado OB/Gyn Society, would allow a woman in a managed health care plan to have access to either her OB/Gyn or family practitioner for women's health care services.

The most contentious issue so far

“... after the Governor pinned our ears back...”

(Continued)

THE LOBBY (Continued)

revolves around the Governor's plan to reintroduce legislation to remove the MD requirement for the state health director. I recently joined CMS leadership represented by Drs. Karlin and Painter, along with Sandi Maloney, Lorraine Koehn, and our contract lobbyist Jerry Johnson for a challenging meeting with the Governor. Because we oppose him on this issue, negotiations began only after the Governor pinned our ears back. Governor Romer offered to help us with bills which may be

more important to CMS, such as patient choice, access, and continuity of care if we would agree to accept a physician as the chief medical officer. (This position would not necessarily be a cabinet level post.) CMS would like to maintain the idealistic approach of having an MD as the state health director, but a more realistic position might be to entertain a compromise. As this article goes to press, negotiations are continuing.

This gives you a flavor for what is currently happening at the Capitol. As usual, I expect interesting events

to unfold throughout the session. Rest assured that your Council and leadership will be there advocating the needs of physicians and medicine. One last reminder, the Colorado Medical Society Alliance is having their legislative day at the Capitol on Friday February 23, and I'm certain they would appreciate your support. As always, if you have questions or concerns please contact the government relations staff at CMS.

Colorado Medical Society 1996 Legislative Digest

SB 041 Creates a fee-limiting subfund and allows the director of the department of regulatory agencies to redirect not more than \$2 of the \$9 excise tax imposed on licensed individuals which shall be deposited into the subfund. Requires that subfund moneys be used to supplement the revenues of boards and commissions so that the annual license fees do not exceed \$150. **Position:** Oppose

SB 049 Continues the Regulation of the Practice of Lay Midwifery. Eliminates the prohibition against dual licensure. Authorizes lay midwives to carry and administer oxygen. **Position:** Oppose

SB 092 Addition of Therapeutic Conditions and Techniques That May Be Used by Optometrists. Includes treatment of glaucoma and iritis plus photo refractive keratectomy as the practice of optometry. **Position:** Oppose

SB 093 Voluntary Payment of Peer Health Assistance Program Fees by Health Care Professionals. Makes peer health assistance a voluntary program. **Position:** Oppose

SB 107 Accountability of Independent Medical Examiners to Patients. Establishes a doctor/patient relationship for providers conducting independent medical examinations. **Position:** Oppose

HB 103 Eliminates homocystinuria and maple syrup urine disease from the "Newborn Screening and Genetic Counseling and Education Act." Requires a second specimen test. **Position:** Support

HB 1073 Establishes a loan repayment program and tax credits as incentives to encourage health care professionals to practice in rural areas. **Position:** Support (Please see "The Lobby" on previous page for more details.)

HB 1125 Public Health & Environment Leadership. Removes the requirement that the Executive Director of this department be a physician. **Position:** Oppose unless amended to our satisfaction (CMS Board 1/12/96)

Other legislation currently being reviewed or monitored

SB 031 Female Genital Mutilation. **Status:** Reviewing

SB 047 Adjustments to the State Medical Assistance Program. **Status:** Reviewing

SB 112 Collection of Data Regarding the Health Care Professional Work Force. Establishes a method for the Director of the Division of Registrations to collect data. **Status:** Reviewing

HB 1015 Post-Delivery Care for Mothers and Newborn Infants Act. Requires insurers that offer maternity benefits to provide 48 hours of inpatient care for a mother and her infant following a vaginal delivery and 96 hours of inpatient care following a cesarean delivery, unless the mother and the attending physician mutually agree to an earlier discharge. **Status:** Monitoring (Please see "The Lobby" on previous page for more details.)

HB 1081 Telemedicine. Requires a Colorado medical licence for any physician who renders services in more than 12 cases per year or who interprets tests or images for the treatment of patients residing in Colorado. **Status:** Monitoring

HB 1082 Allows a woman with reproductive and gynecology health coverage to select from among physicians available under the plan who are OB/Gyn's for her reproductive health care and gynecological needs. **Status:** Monitoring

HB 1162 Deregulation of Fees Charged for Medical Record Duplication. Eliminates the authority of the Health Department to regulate amounts charged by providers for copying records. **Status:** Reviewing

HB 1171 Privatization of the Regulation of Professions and Occupations. **Status:** Reviewing

HB 1188 Revisions to Medicaid Statutes. Included in this bill is a section which prohibits certain providers from self-referral when they treat Medicaid patients. **Status:** Reviewing

R^eference Committee G

by Robert D. McCartney, MD
Alternate Delegate to the
American Medical Association



Several important issues that impact Colorado physicians were reviewed at the most recent meeting of Reference Committee G during the AMA Interim meeting in Washington, D.C. The Committee considers issues on managed health care, quality initiatives, practice parameters and the Physician Review Organization (PRO). Proposals reviewed include:

- The AMA should network with the National Committee for Quality Assurance (NCQA), the private accrediting agency for HMOs, to inform them of the need for physician input into quality issues, policies, medical review, grievance resolution and credentialing;
- The AMA should support health plan "Report Cards" as a means of accountability;
- The AMA should oppose the use of board certification as the sole criteria of inclusion within a managed care physician panel, particularly when applied to young physicians;
- The AMA should oppose pre-screening of patients referred for psychiatric care;
- The AMA should oppose "gag rules" imposed by some managed care companies upon physicians desiring to discuss negative aspects of a particular managed care company's policies with their patients;
- The AMA should support voluntary Point of Service options (POS) in the managed care market. Whether this issue should be a mandatory or voluntary part of a patients' contract with

a Managed Care Organization is debatable.

Issues addressed in the POS debate include:

- Mandates are not currently politically correct;
- Healthy patients cannot anticipate what benefits they will need should they become sick;
- No one should fear giving patients choice;
- Patients are entitled to choice, which includes the least expensive option of a closed HMO panel and no POS option;
- The financial impact of mandatory POS on the national health economy is unknown.

Summary

From the debate it was clear that physicians nationwide are struggling with the changes surrounding managed health care. While many view managed care as the new paradigm to be embraced, many others are struggling to hold on to the old system and wish to forestall change. At the center of all debate, however, was the message brought to the AMA by Cardinal Bernadine of Chicago. He admonished the AMA House of Delegates to embrace the covenant of trust we hold with our patients, the basis of the doctor patient relationship, and foundation of all medical ethics. Despite the financing turmoil that embroils health care, this sacred covenant of our profession must be upheld. Abandon it, and ultimately we fail; preserve it, and despite political and economic upheaval, medicine as a profession will prevail.

"From the debate it was clear that physicians nationwide are struggling with the changes . . . (in managed health care.)"

HIGHLIGHTS OF BOARD OF DIRECTORS MEETING - January 12, 1996

Medical Executives:

Ms. Pennie Joseph extended her appreciation to COPIC for the medical executives' invitation to attend their retreat in Vail, Colorado this April. She then presented Ms. Mary Lee Johnson with a retirement gift.

AMA Delegation:

Ray Painter, M.D. announced the election of Richard Allen, M.D., to the AMA Council on Education. The resolution on third party reimbursement methodology presented to the AMA by our Colorado Delegation passed the AMA House of Delegates, with language included to strengthen the resolution.

Colorado Physician Network:

David C. Martz, M.D. presented an update on the Colorado Physician Network. CPN is growing at a rapid rate, with 2,000 physician members as of this writing. Dr. Martz stated that the December 31, 1995 deadline is a "soft" deadline, and that no applications are being returned.

Board of Directors:

The Board approved a motion submitted by the Workers' Compensation/Personal Injury Committee for CMS to oppose mandatory Level I Accreditation.

Call for Nominations

The Secretary of the Colorado Medical Society (Executive Director, Sandra L. Maloney) has announced a ***Call for Nominations*** for the following offices of the Colorado Medical Society:

President-elect

Vice Speaker of the House of Delegates

AMA Delegate

AMA Alternate Delegate.

The CMS Nominating Committee will meet during the Interim Meeting of the House of Delegates, March 23-24, 1996, to hear from those persons expressing an interest in being nominated for the above offices.

AMA President to speak to CMS Interim Meeting



Lonnie R. Bristow, MD, an internist from San Pablo, California, became president of the American Medical Association (AMA) in June 1995. A member of the AMA Board of Trustees since 1985, Dr. Bristow served as president-elect since 1994, as chair of the Board of Trustees from 1993 to 1994, as vice-chair from 1992 to 1993, and as a member of the Executive Committee since 1990. He had represented the AMA as a commissioner to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) from 1990 to 1993. He served the AMA Education and Research Foundation first as its secretary-treasurer from 1986 to 1988, and then as its president from 1988 to 1990.

Before his election to the Board in June 1985, Dr. Bristow served as an alternate delegate since 1978 and as a delegate since 1979 to the AMA House of Delegates from the American Society of Internal Medicine. In 1979, he became a member of the AMA's Council on Medical Service, which he chaired from 1983 until his election to the Board of Trustees. Dr. Bristow has long been active in organized medicine. Among the positions he has held are chair of the Section on Internal Medicine of the California Medical Association and president of the California Society of Internal Medicine and later, the presidency of the American Society of Internal Medicine. He was also honored in 1987 by his election to membership in the Institute of Medicine of the National Academy of Sciences.

Dr. Bristow's service in the professional community has been and continues to be diverse as illustrated by his appointment to serve on the Institute of Medicine's Committee on the Effects of Medical Professional Liability on the Delivery of Maternal and Child Health Care from 1987 to 1989, his appointment by the Surgeon General to serve on the Federal Interagency Committee on Smoking and Health in 1988, and his appointment by the Secretary of Health and Human Services to serve on both the Center for Disease Control's HIV Prevention Advisory Committee and the 1989 Quadrennial Advisory Council on Social Security.

Born April 6, 1930, Dr. Bristow received his BS degree from the College of the City of New York in 1953 and his MD degree in 1957 from New York University College of Medicine. He completed his internship in 1958 at San Francisco City and County Hospital and served his residency in internal medicine at U.S.V.A. Hospital, San Francisco, Francis Delafield Hospital (Columbia University Service) New York City, and U.S.V.A. Hospital, Bronx, New York. In 1981 he completed an additional residency in occupational medicine at the University of California, San Francisco, School of Medicine. Dr. Bristow is a diplomate of the American Board of Internal Medicine and a master of the American College of Physicians. He has an honorary Doctor of Science degree (1994) from the Morehouse College School of Medicine, Atlanta, Georgia; an honorary Doctor of Science degree (1995) from the



*Lonnie R. Bristow, MD,
President of the
American Medical Association*

Wayne State University School of Medicine, Detroit, Michigan; and an honorary Doctor of Science degree (1995) from The City College of The City University of New York, New York. He is on the staff of Brookside Hospital, San Pablo, California.

Dr. Bristow has written and lectured extensively on medical science as well as on socio-economic and ethical issues related to medicine. He currently serves as a reviewer for the Journal of the American Medical Association. Dr. Bristow and his wife, Marilyn, reside in Walnut Creek, California, and are the parents of two children.

Colorado Medical Society 1996 Interim Meeting Schedule

To be held at the CMS offices

Friday, March 22, 1996

12:30 pm-1:00 pm	Finance Committee
2:00 pm -5:00 pm	Board of Directors

To be held at the Holiday Inn Southeast (Parker Road @ I-225)

Friday, March 22, 1996 -

6:30 pm-9:00 pm	Women in Medicine
-----------------	-------------------

Saturday, March 23, 1996

6:30 am-5:00 pm	Registration
7:00 am-10:00 pm	Office open
7:00 am-8:00 am	Reference Committee Members
7:00 am-8:30 am	Nominating Committee Open Forum
8:00 am-8:30 am	Credentials Committee
8:30 am-9:00 am	House of Delegates - Opening Session
9:00 am-12:00 Noon	General Membership Meeting
	Keynote: David Ginsberg
12:15 pm-1:45 pm	Working Lunch featuring panel discussion with AMA President Lonnie Bristow, MD, and Drs. Barbara Reed, M. Ray Painter, Robert B. Sawyer, Charles Mains, and Jack Berry
2:00 pm-4:00 pm	Reference Committee 1*
3:00 pm-5:00 pm	Reference Committee 2*

**Depending on the number and content of resolutions, there may be only one Reference Committee.*

Sunday, March 24, 1996

6:30 am-11:00 am	Registration
7:00 am-12:00 N	Office open
7:00 am-8:30 am	Arapahoe caucus
7:00 am-8:30 am	Aurora-Adams caucus
7:00 am-8:30 am	Boulder caucus
7:00 am-8:30 am	Clear Creek Valley caucus
7:00 am-8:30 am	Denver caucus
7:00 am-8:30 am	El Paso caucus
7:00 am-8:30 am	Larimer/Weld caucus
7:00 am-8:30 am	Pueblo/Western Slope caucus
8:15 am-8:30 am	Credentials Committee
8:30 am-9:30 am	House of Delegates - Closing Session
9:30 am-11:30 am	State of the Society

*his portion goes
to CMS*

Interim Meeting Registration

1996 Interim Meeting of the Colorado Medical Society, March 23-24, 1996, Holiday Inn Southeast

Name (Please type or print) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(Reservation deadline is March 7, 1996. Reservations accepted on a first-come, first-served basis)

Number of Reservations	Amount Enclosed
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12:15 pm - 1:45 pm Luncheon

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MEETING REGISTRATION

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MESSAGES

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WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

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directly to the
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Interim Meeting
March 23 - 24, 1996

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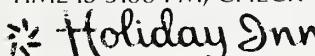
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6 pm Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

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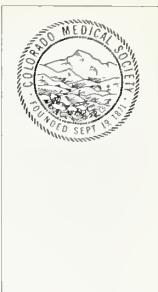
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Physician Services: Supply and demand

We should all be concerned about an impending oversupply of physicians. If you would like to review the recent literature on this, the following articles are of interest.

The most dramatic statement of this problem is contained in the following report, which recommends a 20-25% reduction of medical school placements by the year 2005. They further recommend that this be accomplished by closing medical schools.

"Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century," The Third Report of the Pew Health Professions Commission, November 1995.

Estimates of the numbers of surplus physicians in the year 2000 have varied from 31,000 to 165,000 in the following articles:

Jonathan P. Weiner, *"Forecasting the Effects of Health Reform on US Physician Workforce Requirement: Evidence from HMO Staffing Patterns,"* Journal of the American Medical Association, 272:222-230, July 20, 1994.

Richard A. Cooper, *"Seeking a Balanced Physician Workforce for the 21st Century,"* Journal of the American Medical Association, 272:680-687, September 7, 1994.

Sandy Gamliel, et al., *"Managed Care on the March: Will Physicians Meet the Challenge?"* Health Affairs, 14:131-141, Summer, 1995.

Richard A. Cooper, *"Special Communication: Perspectives on the Physician Workforce to the Year 2020,"* Journal of the American Medical Association, 274:1534-1543, November 15, 1995.

Alvin R. Tarlov, *"Estimating Physician Workforce Requirements: The Devil is in the Assumptions,"* Journal of the American Medical Association, 274:1158-1160, November 15, 1995.

Lest you think that we have a scarcity of primary care physicians, please read these articles:

Michael E. Whitcomb, *"A Cross-national Comparison of Generalist Physician Workforce Data: Evidence for US Supply Adequacy,"* Journal of the American Medical Association, 274:692-695, September 5, 1995.

James E. Dalen, *"US Physician Manpower Needs: Generalists and Specialists: Achieving the Balance,"* Archives of Internal Medicine, 156:21-24, January 8, 1996.

The only consolation may be that the Richard Cooper article from November 15, 1995, is the least pessimistic with a surplus of only 31,000 in the year 2000, a maximum surplus of 62,000 in 2010 and a subsequent narrowing of the supply/demand gap.

Lorraine Heth in the Colorado Medical Society Office at 930-0409 or 800/654-5653, x2409 can send you the articles if they are not available in your hospital medical library. Next month we will look at physician hospital organizations.

Leigh Truitt, MD

Important Notice To All CMS Members:

Public Access to Physician Data

RES-31: Improved Public Access to Data Concerning Physicians was referred back to the Health Affairs Council for rewording based on the advice of legal counsel at the 1995 Annual Meeting of the Colorado Medical Society (CMS). Legal counsel worked with the Data Committee and a revised resolution was passed by the Health Affairs Council in September. This resolution was then approved by the CMS Executive Committee and, subsequently, by the CMS Board of Directors in November. The action plan for this resolution is being developed for final implementation in April of 1996. This plan involves you, the physician community.

With that statement in mind, the following are some questions you may ask, and the answers supplied by Colorado Medical Society.

Q. Why this sudden interest in physician data?

A. The push for access to physician-specific data is continuing to grow. The physician community is perceived as being less than cooperative in this area. To help you respond in a positive and proactive manner, the **Physician Profile Project** was created in response to RES-31. This resolution states that CMS encourages the availability of useful, valid information on individual physicians that facilitates informed decisions by purchasers and continuous quality improvement efforts by providers.

Q. The big issue has been "outcomes data"; why isn't this included?

A. The resolution recognizes that while reliable and valid outcomes data for individual physicians are not yet available, there are some data which are already available and can be of use to patients. To that end, it states that CMS will work with the Board of Medical Examiners (BME), credentialing agencies and others to facilitate consumer access to the defined data and that CMS will publish and disseminate a patient brochure explaining how to access this information.

Q. What specific information is going to be included in this?

A. CMS is currently working with Copic Insurance Company and Gadian Corporation (physician credentialing service) to implement this resolution. **In a short time, each physician will be receiving from Gadian a profile which lists individual information for the following items:**

- a) medical school from which you graduated and date of graduation;
- b) graduate medical education;
- c) specialty board certification through ABMS (American Board of Medical Specialties) or AOA (American Osteopathic Association);
- d) number of years in practice;
- e) names of hospitals where you have privileges;
- f) location of your primary practice setting;
- g) identification of any translating services that may be available in your office;
- h) whether or not you participate in Medicaid and/or Medicare, and;
- i) final BME disciplinary actions.

Q. What is the physician expected to do?

A. You will be asked to confirm the accuracy of the data. If the data is accurate, you may copy the profile and make it available to your patients. Any changes should be returned to CMS. You will then receive a clean copy of the information, on Gadian letterhead, which you can duplicate and make available to your patients beginning in April.

Q. How were the data included in this profile chosen?

A. In determining what information should be included, CMS looked for data which was currently available to the public, (yet sometimes difficult for the public to access) which might be of use to patients in choosing their health care providers. We were very clear in our deliberations that malpractice claims were not useful information for anyone; however, final BME disciplinary actions, which are already public information, may be of more use.

Q. Is someone requiring that the physician participate in this project?

A. No! Participation in this project is completely voluntary and at no cost to you.

Q. What will be done to let the public know about this data?

A. The project will be developing a community education campaign. It will focus on informing the public about what data are useful and what are not, what data are currently available and how it can be accessed, and how to be a good patient and consumer of health care.

Q. How will the patient get this information?

A. We would like the patients to be able to access this information **through you, their physicians, and only through individual physicians' offices.**

Q. Will this information be considered reliable information coming from a physician's office?

A. Yes, however, the patients should be able to come to you for the information and know that the information provided has been checked by an outside agency. That is why you will receive your profile from Gadrian on Gadrian letterhead.

Q. Then what is the advantage of getting the information from me, the physician?

A. Getting the information from you allows your patients to discuss with you those elements that are important to them. This also tells your patients that you support their desire to make informed choices regarding their physician. You are then sure that your patient will receive complete, accurate information that you have reviewed and approved.

Q. The patient still has no "outcomes data", so what value will these data be to the patient?

A. While the data elements contained in these profiles may not be the "outcomes" data that many are looking for, they are available, useful and an important first step in a dialogue between physicians and the public about provider specific information. **Please participate.**

Look for your letter from Gadrian in February and complete and return it as soon as possible. We hope to have the data in your hands and the community education campaign off and running by mid-April.

If you don't receive the data questionnaire, call Colorado Medical Society and ask for someone handling the "Provider-specific data" program.



by **Bill Pierson, Director**
Communications & Member Services

Here are some interesting and somewhat mystifying membership figures for Colorado Medical Society at end-of-year. Interesting because it is always interesting to see an organization of Colorado Medical Society's length (since 1871) and girth (covering a broad range of member services) continue to grow. Mystifying because we don't know which of the many organizational services we offer affects growth the most. For the 5,146 members there are probably nearly as many reasons for membership. In the majority, however, are likely to be those who appreciate how much CMS does for Colorado

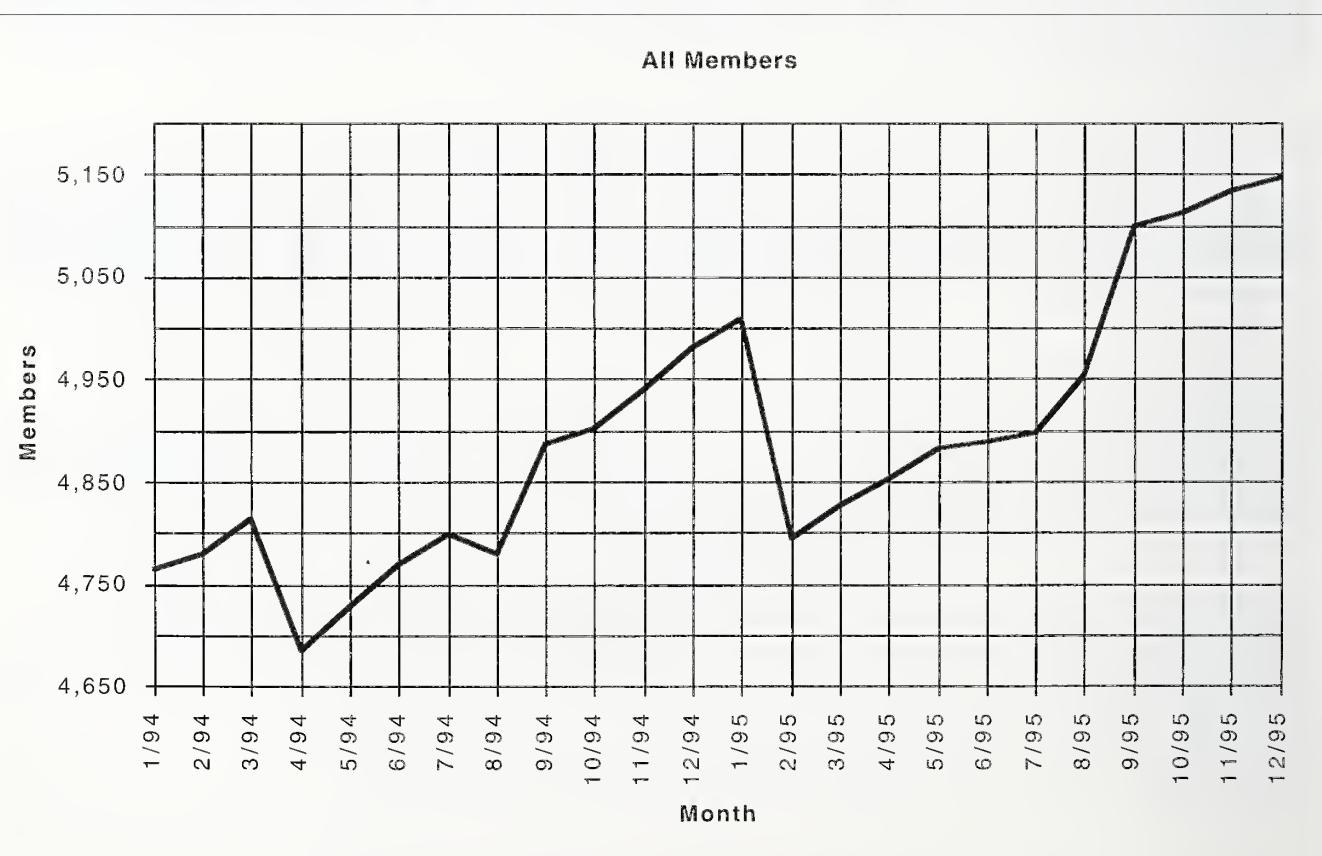
physicians and patients in the legislative arena. Mystifying, too, because, as of December 4, 1995, the Colorado State Board of Medical Examiners (BME) listed 14,120 licensed physicians in the state. The BME classifies 11,691 of these licensed physicians as active. (Defining "Active" by BME standards adds to the mystique.)

The American Medical Association (AMA) reports there were 8,189 total non-federal physicians as of January 1, 1992. On January 1, 1994 that number was 8,895. (Non-federal physicians are all physicians

except those directly employed by the US Government, i.e. military, VA and the like).

The AMA lists total physicians involved in patient care in Colorado: January 1, 1992 = 6,774
January 1, 1994 = 7,268

As of December 31, 1995, CMS had 5,146 members. The CMS Membership and Member Services Divisions, particularly, aspire to continued growth and improvement of member services. We'll be happy to entertain your suggestions on how we can improve.



Women in Medicine Section Leadership Conference 1996



“Women Empowering Women”

The Women in Medicine Section (WIM) of the Colorado Medical Society provides a means for women physicians to network and participate in organized medicine. In 1995 WIM organized a conference to address issues of importance to women physicians. With over 130 attendees, the conference was a huge success. This year's conference, to be held at the Embassy Suites Hotel in Englewood on April 20, 1996, will be even better.

The keynote speaker will be Dr. Linda Hawes-Clever, an internist from California and the editor of the *Western Journal of Medicine*.

After the keynote speaker, the following five workshops are planned:

- **Medical Marriages:** The purpose of this workshop is to introduce, discuss, and seek solutions to the challenges that arise when one or both partner(s) in a marriage is a doctor. A panel of four physicians and their spouses will participate. Susan Heitler, Ph.D., an expert in conflict resolution, will moderate this workshop.
- **The Glass Ceiling:** Harvard psychiatrist Sharyn Lenhart, MD, will explore the obstacles women encounter when advancing in careers traditionally dominated by men.
- **Impact of Careers on Children:** This workshop will examine the challenges professional parents face when raising their children.
- **Team Management:** Les Wallace, Ph.D., founder and president of Signature Resources – an international management consulting firm – will explore ways to enhance productivity and satisfaction in the workplace by creating a team environment. His style of management utilizes proactive, coaching techniques.
- **Effective Speaking Skills:** Dennis Phillips, Ph.D., Associate Professor of Speech Communications at Colorado State University, will lead this workshop. Participants will have three to five minute speeches videotaped and analyzed by Dr. Phillips.

This conference promises to be an empowering experience for all participants. Please mark your calendars and watch for the upcoming flyer with more details and registration information.

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Willing and able but no opportunity ... until now

Retired doctors have been willing and able to provide care to the medically indigent, but the medical liability insurance requirement of state licensure has always blocked the opportunity ... at least until now.

Copic has been attempting for a number of years to find a legislative solution to keep the heavy weight of malpractice premiums from discouraging retired physicians who want to provide pro bono medical care.

After the defeat in April 1995 of the latest effort — HB 1255, sponsored by Rep. Phil Pankey of Littleton — Copic's Board decided at its October 1995 meeting to take matters into its own hands to resolve this problem for its physicians.

Recognizing that these doctors represent a valuable resource to Colorado communities, Copic is providing a partial solution to the

problem of indigent health care by providing professional liability coverage at no charge to all licensed and qualified retired Copic physicians who wish to provide medical care without pay. The program should be ready for applications by the end of the first quarter or early in the second quarter of 1996.

"Retired physicians are a valuable resource for Colorado's indigent and medically underserved," said Jerome M. Buckley, M.D., Copic's Chairman and CEO. "While we're sensitive to the state's desire to protect its citizens, we firmly believe that we should all be making it easier — not harder — to do the right thing. We are committed to removing the roadblocks in this situation.

Physicians who wish to take advantage of this new program must complete a brief application, receive formal approval from Copic, and meet the following requirements:

- The physician must be fully retired from active practice.
- The physician must have been insured previously by Copic and have obtained tail coverage.
- The physician must possess a valid license to practice in Colorado.
- The physician must provide medical services without pay.
- The physician must refrain from performing obstetrical, prenatal, invasive, or surgical procedures and may not provide inpatient hospitalization care.

We at Copic intend to continue to pursue a legislative solution, but are excited to offer this relief to retired Copic physicians, enabling these valued professionals to lend their expertise to Colorado communities. You physicians have been willing and able and Copic is pleased to assist in providing the opportunity.

CPN -Our Field of Dreams

"Build it and they will come..." These were the words of the visionaries in the award-winning movie, "Field of Dreams", and they have echoed in our ears for the past two years as we have developed the Colorado Physicians Network (CPN).

And come they have! After only two months of open physician recruiting, approximately one third of practicing Colorado physicians have sent in their application forms and enrollment fees. We are thrilled by this initial response, as obtaining

a large panel of providers is crucial to our commitment to choice for Coloradans.

Likewise, as employers and consumers are hearing of our unique product, Rocky Mountain Physicians Choice, the phone is ringing off the hook for information on when and how to sign up.

Our ideal goal is to have **all** Colorado physicians impaneled if possible. From a practical standpoint, however, we would be pleased with a final number between half and three-

fourths of the over 6000 medical doctors in the state.

If you have not yet signed up, there is still room and time for you to join. If your practice size or style is such that the enrollment fee has been a deterrent, please call and inquire about options that would remove this barrier for you.

We want you to share in the CPN dream coming true. Don't let this opportunity pass you by! Call 1-800-843-0719 today and make a difference in Colorado.



Dr. Candlin meant a lot

Bill Pierson
"Ruminations"

Thank you for the fine article about Francis T. Candlin in the December issue of *Colorado Medicine*.

Francis made the trips to Denver for COMPAC meetings worth while. He always had a story before the meetings, and made several witticisms and fun remarks during the meetings. He obviously enjoyed life and made life more fun for others.

Joseph S. Pollard, MD
Colorado Springs



Remember

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues.

1996 is shaping up to be a critical year in medical legislation, so help however you can.

Medical School says there's no chiropractic clinical training planned

To the Editor:

A number of physicians have asked us about the January 12 *Rocky Mountain News* story which said that a new University of Colorado residency program in chiropractic was being established. The University of Colorado School of Medicine Graduate Medical Education (GME) program does not and has no plans to offer a CU training program in chiropractic. The University Hospital Spine Center will offer comprehensive back care delivered by a number of specialists. One CU orthopaedist (also trained in chiropractic) will incorporate chiropractic procedures when appropriate for the patient's condition. The University of Colorado agreed to permit one chiropractic graduate from a Los Angeles school, per semester, to observe medical care for orthopaedic patients in the Spine Center.

Carol M. Rumack, MD
Associate Dean for GME
University of Colorado
School of Medicine

Medical Archives earns early plaudits

Editor:

Congratulations on adding the "Medical Archives" section authored by John Lightburn, MD, to this journal. In the early days of my medical career, I had the good fortune of being a member of the Crawford Long Medical Society in the state of Georgia. Dr. Long did his initial evaluations of ether anesthesia only 20 miles from the community in which I practiced at that time. At one of the first medical society meetings, I had the good fortune of being welcomed to the community by an elderly physician whose first comment was "doctor, would you like to shake the hand of a man who shook the hand of Dr. Crawford Long?" I still remember that as a delightful way to establish both an emotional and a physical connection to those exemplary physicians who paved the road with their hard work and dedication that the rest of us have trod with scarcely a glance backward to thank them.

I can think of no one better prepared to provide us with our historical roots in Colorado than Dr. Lightburn who himself is one of those dedicated physicians who stands as a model for the rest of us. I look forward, with keen anticipation, to his endeavors in shining the spotlight backwards into the history of medicine to illuminate those leaders of our profession.

George O. Thomasson, MD
Denver



*John L. Lightburn, MD, Historian
Colorado Medical Society*

He Changed a Hammock into a Hospital

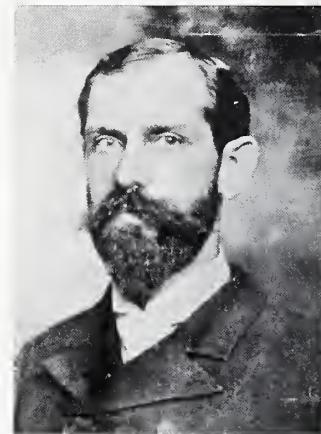
***"Trucks hauled away that
hammock that was
Grasshopper Hill, and ...
on the hill that was
Dr. Perkins' dream ...
the massive Presbyterian/
St. Lukes Medical Center
(was built)."***

I. B. Perkins, MD - 26th president of the Colorado Medical Society; a biographical sketch.

It was 100 years ago that he served as president. Although there are many other interesting and colorful medical pioneers that we hope to write about in the future, 100 years is a nice round number. So Isaac Basil Perkins is our choice for this month.

Dr. Perkins was born in Farmington, Missouri on August 8, 1859, the son of Rev. Joseph Perkins, whose family numbered four sons and five daughters. All four sons became physicians. Isaac started his medical education at Missouri Medical College (which became Washington University) in St. Louis and finished his education at Denver Medical College, graduating in 1886. One year after receiving his MD, he was elected secretary of the Arapahoe County Medical Society, (at the time Denver was the county seat of Arapahoe) and six years later he became president of the Denver Medical Society. In June of 1895, Dr. Perkins was elected President of the Colorado Medical Society at the age of 36!

His picture published in the CMS Transactions revealed a handsome young man with a striking, almost flamboyant mustache and beard. Described as affable, genial, outgoing and uncritical, one can imagine him as a charismatic young man striding into the surgical suite. A picture taken in 1920 revealed a more subdued gentleman with sensitive, almost sad eyes, perhaps reflecting the years of hard work. At the end of his term, he



*Isaac B. Perkins, M.D. 26th
President of the
Colorado Medical Society 1895*

presented the customary Presidential address to the society at its 26th annual meeting held this time at the Brown Palace Hotel, which had replaced the Windsor as the premier hotel in town. You may find the following excerpts from his address interesting.

"We are now about to close another successful year of our existence as a medical society ... The vigorous infant, born of noble parentage in 1871, may now justly be called an adult; one competent to take the lead in all matters pertaining to the health of the public and the welfare of the profession in our state. This has been clearly shown by the number as well as the scientific character of the papers read at this session ... The most startling scientific discovery of years, and one that will be of incalculable benefit to physicians and surgeons, is that of Professor William Conrad Roentgen, given to the public about six months ago. At first the report that a photo-

graph or correct picture of the skeleton could be taken through the soft tissues of the body, a bullet or foreign body in the flesh could be accurately located, and all this with splints and dressings intervening, was thought by many to be only the vision of a scientific dreamer. But in a few weeks successful experiments in almost every city of the world demonstrated the truth of the

reported discovery, and the name of Roentgen was immortalized." Dr. Perkins went on to predict diagnostic and therapeutic uses of the x-ray.



Dr. Perkins
circa 1920

After his presidency, Dr. Perkins devoted his skill and energy to an increasingly busy surgical practice, doing most of his work at St. Luke's Hospital where he was often chief of staff. Like many others in that era, he charged according to the patients ability to pay. Though loyal to St. Luke's, he was convinced that the growing city of Denver needed another hospital. His dream was to build a new hospital on Grass-

hopper Hill, a six block hammock with weeds so high that children played hide and seek in it. Following months of campaigning and promot-

ing, the money was raised after Dr. Perkins approached the Synod of the Presbyterian Church. On June 26, 1921 the cornerstone was laid for the new Presbyterian Hospital.

Dr. Perkins was appointed the first chief of staff at the new Presbyterian Hospital, but failing health prevented him from filling the position. He spent his last years writing poetry and investing, suffering devastating losses in the stock market crash of 1929 just before his death on November 7, 1929. Years later, trucks hauled away the hammock that was Grasshopper Hill, and the stately building on the hill that was Dr. Perkins' dream has become the massive Presbyterian/St. Luke's Medical Center. What would Dr. Perkins say now?

An afterthought:

Although we hope to continue presenting anecdotes and biographical sketches from the Society's past, there are other responsibilities of the historian which need attention. For example, in 1971 the Rocky Mountain Medical Journal celebrated the 100th anniversary of the Colorado Medical Society with pictures and biographical sketches of the first 100 presidents. Dr. Bradford Murphey, the historian for several years, made significant contributions to the archives that provided the data for those anniversary editions. Indeed, one of the most valuable aspects of the archives are the anecdotes and vignettes that give us insight into the character and personality of the members and officers who have so dramatically shaped the course of the society and medical care in Colorado and the nation.

I have become aware that the archives should contain more than the back issues of this journal and minutes of various meetings. It is the historian's task to record the struggles and dreams, the defeats and victories that are a part of the growth and evolution of this organization. But collecting and recording such material for archives is more than a single person can do. Since many of the component societies already have historians, it is hoped that the other societies will elect or appoint historians. When that is accomplished, perhaps we can all form a state historical committee in which we can collaborate in developing archives that will be truly useful to our future colleagues.

In addition to the help we hope to receive from these historians, we welcome contributions, suggestions, ideas or observations that can enrich the archives of the past or ongoing history of our society.

John Lightburn

Editor's Note:

It was on the slope of "Grasshopper Hill" that Colorado Medical Society encamped for a number of years. Prior to that, CMS was headquartered eleven years in its own building at 18th and Williams. CMS officed in the Republic Building at 16th and Tremont from 1933 to 1962.

The summit of "Grasshopper Hill" was the site of Presbyterian Hospital, but at the lower southwest corner at 19th and Franklin stood the **Denver Medical Library Foundation** building. This edifice for a number of years housed the Denver Medical Library, the Denver Medical Society, Colorado Medical Society, the Colorado Foundation for Medical Care and the Colorado Academy of Family Practice.

It's now hard to imagine all these organizations existed under one roof. The only one remaining on "Grasshopper Hill" is the **Denver Medical Library**, which is now located in the new Presbyterian/St. Luke's Complex at 20th and Franklin Street. Denver Medical Society stayed faithful to the "Hill", and is located nearby at 1850 Williams.



Cancer Control Plan Available

A comprehensive statewide Cancer Control Plan has been developed by the Cancer Control Plan Advisory Committee, a group comprised of consumers and members of government and private organizations involved in cancer control. The plan outlines strategies for reducing cancer incidence and mortality and improving the care and quality of life of individuals diagnosed with the disease. The strategies encompass behavioral changes including improved diet and exercise, reduced use of tobacco and better access to the best diagnostic and therapeutic procedures available.

The plan focuses on six of the most commonly diagnosed cancers in Colorado: lung, colorectal, female breast, cervix, prostate and melanoma; all of which are preventable or detectable at early stages.

The Cancer Control Plan is now available through the Cancer Prevention and Control Program of the Colorado Department of Public Health and Environment. Call (303) 692-2600 to receive a copy of the plan.

9Health Fair

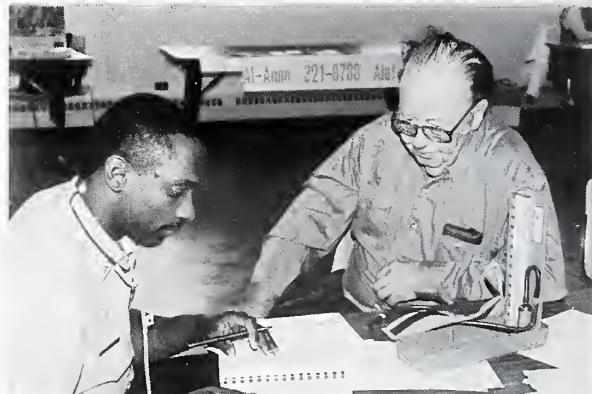
by Vicki Godbey
Executive Director

While it is only the first part of the new year, the 17th annual statewide 9Health Fair, scheduled for **April 13-21**, is gearing up. The staff, volunteers, and most importantly, the participants are reassured knowing that the Colorado Medical Society has endorsed, once again, the efforts of 9Health Fair.

Volunteers are the lifeblood of this statewide effort to provide health education and basic health screenings the public. Physician board or committee medical members include Drs. Robert B. Sawyer, Eugene Weston, Sherry Laubach, Elizabeth Ritchey, Martha Johns, and Robert Bogin. They and others provide guidance. Some of their ongoing medical efforts entail: 1) improvement of the blood chemistry screening, 2) evaluation of the efficacy of screenings, 3) methods to include more practitioners, 4) ability to provide smaller and more portable equipment for easier transportation, particularly to rural areas and 5) collaboration with agencies which provide mammography and childhood immunizations.

It's our understanding that many physicians are advising their patients to visit the 9Health Fair, have their blood drawn and send a copy to their office. The blood reports are now cumulative for a three-year period, making it easier for the physician to compare results from year to year.

Sponsors of the 9Health Fair



1995 9Health Fair volunteer gathering vital statistics.

include Provenant Health Partners, MetraHealth, a United HealthCare company, Lions Clubs of Colorado, the National Guard and 9News.

Physician volunteers statewide are needed to assist in this worthwhile project. Time commitment is generally for a morning, either a weekday or a weekend day. For information, please call the Colorado Medical Society at 800-654-5653, Ext. 2418 or 9Health Fair at (303) 698-4455.

New Bonfils Center Receives Accreditation

Bonfils Blood Center is the first community blood center in the U.S. to receive accreditation by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP). Bonfils' laboratory was awarded a two-year CAP accreditation based on the results of a recent on-site inspection. The CAP Laboratory Accreditation Program is recognized by the federal government as being equal to or more stringent than the Clinical Laboratory Improvement Act of 1988.

William C. Dickey, Bonfils' Medical Director/President/CEO, noted, "The CAP inspection is an expansion of our commitment to quality."

Bonfils announced its move to new quarters on the former Lowry Air Force Base, and will have expanded capabilities in its new quarters of 150,000 square feet.

Physicians Needed to Host Student Visits to Rural Medicine Practices

The University of Colorado Cancer Center Education Office seeks to expose college and medical students to rural medical practices. This exposure, if early enough in the career planning of such students, is hoped to influence their eventual interest in entering a rural practice themselves.

Physicians interested in having a pre-medical or medical student visit their practice for one to three days (preferably with overnight accommodations provided) should contact Suzi Shevell at the Colorado Medical Society (303/779-5455). Students will be available for these visits from June through

August each year. A list of physicians will be updated (extending one begun last year) and matching of physicians and students, by mutual agreement, will be facilitated through the Cancer Education Office (303/270-3000) under the direction of Richard F. Bakemeier, MD.

Longer term assignment of medical students to medical practices around the state will continue to be arranged through the Area Health Education Centers (AHEC) system. Information can be obtained from the office of Curt Stine, MD, of the University of Colorado Department of Family Medicine (303/270-5191).

CORRECTION

To Regulations re: Prescriptive Authority for Physician Assistants

The December issue of *Colorado Medicine* carried an update on the rules and regulations with regard to the physician/PA working relationship. It stated that recent regulatory changes no longer required the name of the supervising physician on the prescription pads utilized by PAs. However, the statute still mandates that **"Each written prescription order shall be on the supervising physician's prescription order form and signed by the PA; and shall contain in printed form the name, address and telephone number of the supervising physician and the name of the PA."** Therefore, this specific regulatory change did not go into effect, the statute has precedence and...

PAs are still required to use a prescription pad on which the supervising physician's name is imprinted.

Communications Division takes new approach to its mission

In view of the tremendous change in medical practice and all of health care delivery, Colorado Medical Society's Division of Communications and Member Services has undergone a restructuring. In an attempt to stay abreast of the changes in the medical profession which impact our members, we

must be able to react more quickly and, if at all possible, be ahead of the changes. More and more, I have felt we needed a new, less traditional approach to communicating these issues.

From my continuing analysis of information needs of our members, I believe the focus will be on state and federal legislative issues and how they impact the medical practice. For that reason, I have appointed Mr. Chet Seward as Communications and Member Services Administrative Assistant. He will have a great deal of latitude, including a more focused approach to legislative and socio-economic issues reporting.

Chet has had limited experience in the organizational field, but his training includes a Bachelor's degree in English and Political Science from Augustana University in Rock Island, IL. He also holds a Master's Degree from the Univ. of Denver Graduate School of International Studies.

I regret having to make seemingly abrupt staff changes, but I am certain that the breadth of Chet Seward's interest and his enthusiasm will serve CMS membership well.

Bill Pierson, Editor



Chet Seward



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*Publication of any advertisement in **Colorado Medicine** is not an endorsement by the Colorado Medical Society of the product or service. **Colorado Medicine** magazine is the official journal of the Colorado Medical Society, and is authorized to carry **General Advertising**.*

◆ PROFESSIONAL OPPORTUNITIES

COLORADO SPRINGS - Family practice opportunity to assume a 36 year practice in Colorado Springs, Co. Call (719)-632-6676. 01/0296

PHYSICIAN WANTED! Looking for a physician board eligible in Family Practice or Internal Medicine to join practice in Denver area. Please fax CV to (303) 355-2490. 3/1295

OFFICE SHARE IN CHERRY CREEK NORTH—Primo location for surgical specialty or half time. Call Shelly at 355-1809. 3/1295

FAMILY PRACTICE - Seeking BE/BC family practitioner with OB skills to join a busy family practice group in an attractive, fully equipped facility. The departure of a physician has created an opening and the successful candidate will assume a full load of patients. The practice is located in Windsor, Colorado, which is located in the center of a triangle connecting the fastest growing towns along the front range. It is 15 miles from Greeley, Loveland, and Fort Collins. Lifestyle is important to the group as well as to the people in the community. The schools are consistently rated among the best in the state. Interested candidates may mail CV to: Sherry Kozero-Roth, North Colorado Medical Center, Physician Support Services, 1801 16th St., Greeley, CO. 80631 or FAX to: (970) 350-6644. 03/1295

OCCUPATIONAL MEDICINE-FAMILY PRACTICE Mercy Medical center of Durango Colorado seeks BC/BE family practice physician with experience/certification in occupational medicine to work with family practitioners and orthopedic surgeons. Excellent quality of life, salary and benefits. Send CV and letter to Bob Conrad, Vice President, Mercy Medical Center, 375 E. Park Avenue, Durango, Colorado or call 970-382-1273. 03/1295

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FAMILY PRACTICE

opportunities include:
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NATIONWIDE - Opportunities for the following: IM, DP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, PO Box 904, Tremont IL 61658 or call 800-831-5679, FAX (309) 952-5842. 22/594

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1/296

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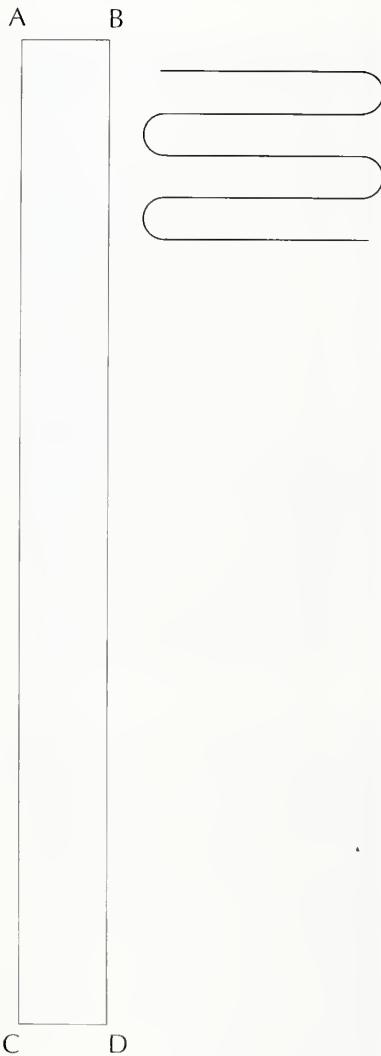


RUMINATIONS

(def chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Boustrophedon: **"As the oxen go, so goes the plow."**



Once in a while I go into those cobweb-strewn corners of my mind, fishing around for something I've long ago put aside. This sort of mindsearch occurs when I am reminded of something from the past. The exercise is a lot like going into the long-closed attic of an old house: much of the contents put away in boxes and containers of odd shapes and sizes, none clearly marked or identified. I might even think I can detect the musty attic odor.

The other day I heard on the radio that the "paw-paw" (some people call it a "papaw") is making a big comeback as a popular fruit. There may be many of you who didn't know it **was ever** a popular fruit, but in some circles it was. When I heard someone else speak the word I was immediately back in the woods along the Kanawah River valley with my Dad, looking for paw-paws. As I say the word I can taste the banana-like custardy-flavor of the apple-sized fruit. We did that; we'd walk in the woods and he would tell me about things.

I do a lot of this sort of rummaging around in my mind any more, wondering what I know, or what I remember and why.

On another day I was reminded of something else tucked back in a dusty corner: "**boustrophedon**". From a semantic perspective, I have always liked this word. It intrigued me when I first heard it years ago, so I went to its origins. It's variously defined as a form of writing: you write a line from left to right, and then you write the next (parallel) line from right to left, etc.

The term apparently originated with early surveyors: *bous* ox, cow + *strephein* to turn — more at **COW, STROPHE**. The surveyor would view the distant hill and would see the oxen pulling the plow from one side of the field to the other, traversing the side of the hill in this series of precise parallel horizontal lines. Since I don't know much about surveying, I'll let the analogy rest there.

The ancient surveyor's term, "**boustrophedonic**" pretty effectively describes medical practice today: **as politics go, so goes the physician, or as health insurance goes, so go the doctors**. However, most physicians can't decide whether the market is pulling them, or they are pulling the market.

As I was flailing through the cobwebs in my mind, I stumbled on another little box in a corner labeled "loop" and it referred to the "mobius strip" or "Mobius's sheet".

August Mobius was a German mathematician and he found that if you took a rectangle (identified by AB and CD) and placed it end to end A to D and B to C, it formed a loop, but the plane of the loop was continually reversing, top to bottom or outside to inside. This device does many rather surprising things. Maybe I'll get into them in some other "mind rummaging" and I'll show you how you can entertain your grandkids for hours (well, maybe minutes) with August Mobius's sheet.

Concerning health care, we can talk about how a parallelogram can be a loop.

“Your Doctor Will See You Now, Ms. Smith.”

How important is the relationship between patients and their physicians?

COMPAC, the political arm of the Colorado Medical Society, is working day in and day out to strengthen that physician-patient relationship..

COMPAC works for you, the physician, and your patient every day by giving support to those legislative candidates who have illustrated strong support for patient choice.

COMPAC is sending our legislators the message that physicians will stand up for their rights. During this session, the Colorado Medical Society has helped draft a bill which would remove restrictions from managed care contracts which presently prevent physicians from discussing patient coverage under the plan, or recommending treatment outside the plan. Call your legislator and ask him or her to vote for HB 1216, today. (House of Representatives 866-2904, Senate 866-2316)

But **COMPAC** needs your financial help, too. Without your support, **COMPAC**’s job becomes much more difficult, if not impossible. Join the hundreds of other Colorado physicians fighting for the rights of their patients — join **COMPAC** today!

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Physician Recognition Awards

The Colorado Medical Society joins the American Medical Association in recognizing the following physicians for their dedication to excellence in the profession of medicine, as demonstrated in their commitment to continuing medical education.

F. F. Amanatulla
David Bruce Burgess
Thomas Michael Dieringer
Stephan Lance Forstot
John Stephen Gray
Robert Roy Greenheck
Mark Leroy Helm
Robert Jacob Hoehn
Trent Lavern Hovenga
Lawrence Ivan Karsh

Jack Edward Lungstrum
Thomas Alton Merrick
John Doty Newell
Martin Edmund Nowick
Martin Philip Pernat
Susan F. Sanders
Janine Marie Slowinski
William Dueno Stiehm
Marc Harris Tanenbaum
Derek Wm. Williams

LEGAL UPDATE

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

Homebuilding Sites – How to Prevent a Catastrophe

A Boulder District Court jury returned a verdict which, including interest, totaled more than \$11 million. The award was on behalf of a four-year-old girl who was paralyzed below her mid-back as the result of an injury which occurred on a new home construction site in Boulder County. The accident occurred when a drywaller working on the home took his two daughters to the job site with him and, on the same day, the home purchasers were viewing the site with their daughter. Without realizing the children were still in the room, the drywaller lost control of a stack of drywall sheets while attempting to move them, causing the drywall to fall onto the purchasers' daughter.

Under Colorado law, a "landowner" includes any authorized agent or person in possession of real property, and any person legally responsible for the condition of the property or the activi-

ties conducted or circumstances existing on the property. All homebuilders and contractors fall within that definition.

Three legal categories exist to determine the legal rights of a person entering the property. Generally, "trespassers" may only recover for damages willfully or deliberately caused by a landowner. "Licensees" may only recover for damages caused by a landowner's negligence with respect to dangers **created by and known** to the landowner or dangers known but **not** created by the landowner which are not ordinarily present on property of the type involved. "Invitees" may recover for any damages caused by a landowner's failure to reasonably protect against dangers of which he actually knew or should have known.

Another legal concept to be considered is the doctrine of "attractive nuisance." This doctrine specifically allows recovery for trespassing

children when a landowner keeps an artificial condition on his premises which 1) is an attraction to a child, 2) involves an unreasonable risk of injury, and 3) is located in a place where children are likely to congregate. In these situations, the landowner must take reasonable precautions to prevent the intrusion of children and to protect them from personal injury.

Being on the receiving end of a personal injury lawsuit is costly, time consuming and frustrating. There may be litigation costs that your insurance carrier will not pay. You may face an increase in your insurance premiums should responsibility be attributed to you as a landowner.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P. C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

CMS Med Fax.[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax.[®]

by **Montgomery Little and McGrew, P.C.**

legal counsel to the Colorado Medical Society

Canadian Health Care Explores Privatization: Calgary Radio to Feature Denver as Source for Answers

Calgary, Alberta – During the month of March, *The Eyeopener*, a Canadian Broadcasting Corporation (CBC) morning talk show, will compare and contrast the health care delivery systems of Denver, Colorado and Calgary, Alberta.

Alberta currently operates under the nationalized Canadian public system, but it is allowing an increasing number of private health care services. Denver was chosen for the survey because of its highly privatized health care system, recent hospital consolidations and growing numbers of HMOs and other managed care institutions. Moreover, similarities between Calgary and Denver like population, economics and geography also helped to prompt the study says Anthony Connolly of CBC. Through the series of broadcasts, Calgary listeners will explore the advantages and disadvantages of both systems to make their own conclusions about whether they like the Denver system or the Alberta approach.

Connolly notes that the Colorado Medical Society (CMS) will be intricately involved in the process. The broadcasts will focus on two basic talking points: 1)

trends in Denver detailing the physician's, politician's and health care expert's point of view on what is happening; and 2) the hospital perspective (figuratively called "I need an MRI") detailing differences in numbers of hospitals, specialists and availability of technology.

Two panels of professionals will tape discussions at studios in Denver, which will be broadcast during upcoming *Eyeopener* shows. The first panel analyzing trends in Denver will be comprised of current CMS President Joel Karlin, MD, former Colorado Governor Dick Lamm, and Jim Hertel of Healthcare Computers of America. CMS Executive Director Sandra Maloney and Larry Wall, President of the Colorado Hospital Association, will form the second panel.

While he is not a health care expert, Connolly reflects the thoughts of many Canadians by stating, "Our health care system isn't about health care per-say, it's about addressing social issues". However, poor accessibility to quality care, juxtaposed by the rising costs of care, have prompted many Canadians to consider more of a privatized fee-for-service or managed care style system. CMS is enthusiastic about this program. Stay tuned for more details!

Legislative Update

At press time, there are two bills awaiting second readings in the House of Representatives which are "high priority" issues for CMS. They are: HB 1232, Mandatory Health Benefit Plans, "a guarantee renewal" proposal sponsored by Rep. David Owen and supported by CMS; and HB 1264, Health Care Purchasing Arrangements, which CMS also endorses because it prohibits non-medical investors from purchasing provider networks.

Other important bills which survived action in the Senate and are now being heard in the House include SB 49, Registration of Lay Midwives and SB 92, Expanded Scope of Practice for Optometrists. Both bills are opposed by CMS. The lay midwifery bill has been favorably amended. The optometry bill is still of major concern to the medical community. CMS will be working with specialty societies to defeat this proposal in the House HEWI Committee.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Medicare/Medicaid: Update on recent fraud and abuse claims

After a Department of Social Services audit of prescriptions written and laboratory tests ordered over a six month period, a New York physician was excluded from participation in Medicaid for five years and ordered to make restitution of \$451,942 plus interest. The decision was based not upon quality of care issues, but rather on the physician's record-keeping deficiencies. The ALJ found that the physician failed to fully and properly document in patient charts the need for the specific tests ordered and medications prescribed, as required by the applicable regulation. Under settled law, a provider's failure to maintain records showing medical necessity and appropriateness for services furnished constitutes "unacceptable practice" and can form the basis for sanctions.

A New York radiologist was ordered to make restitution of more than \$596,000 and was barred from participating in Medicaid for five years on the basis of record-keeping errors and omissions such that claims for payment from Medicaid were unsubstantiated by the records submitted with the claims. On appeal, the decision was reversed in part based upon a defense similar to "the dog ate my homework". The physician successfully argued that the documentation had been turned over to the Medicaid Fraud Control unit investigating his case, and that when the files were returned, much of the documentation was missing from the files.

In a third case, a physician and his ambulatory surgery center were found guilty of fraud resulting from illegal Medicare billing practices. When HCFA investigated the center, it found that Medicare was billed for overlapping CRNA services: under the center's billing practices a single CRNA working 10 hours was billed out for 27 hours. The physician claimed that he did not know that the billing practices were illegal. However, the jury was instructed that it could find the physician and the center guilty if it determined that they "adopted

an attitude of willful blindness" and "kept themselves deliberately ignorant of Medicare billing regulations." His conviction was upheld on appeal.

The Clinical Practices of the University of Pennsylvania, settled Medicare false billing claims by agreeing to pay \$30 million to the US government. An audit revealed that faculty physicians billed for services actually performed by resident physicians in training, when under the Medicare program the US already pays a substantial portion of the salaries and cost of training residents, and prohibits billing on a fee-for-service basis; that faculty physicians billed for in-patient consultations at the highest coding levels, without reference to the services performed; and that documentation was inadequate.

Medical Malpractice Litigation: Recent Jury Verdicts

After rejecting a settlement offer of only \$20,000, which would have been paid from a fund established by breast implant manufacturers, a Florida woman lost her case against Bristol-Myers Squibb Co.

According to *Lawyers Weekly USA* five of the ten highest verdicts in 1995 were awarded in medical malpractice cases. In Georgia, Kaiser was hit for \$40 million for requiring a sick infant to be taken to a hospital 42 miles from home. Finding against the hospital, a California jury awarded \$98.5 million to the mother of a child rendered quadriplegic after being deprived of oxygen for ten minutes during its delivery at Long Beach Community Hospital.

In New York a woman claimed that her child was brain damaged as a result of the performance of an early cesarean section by a physician who suspected the mother had cancer. The jury awarded them \$43 million.

New York's insurance fund created ten years ago to help pay large medical malpractice awards now totals \$2.3 billion. Only \$57 million has been paid out so far. Blue Cross and Blue Shield Plans filed suit claiming that the state has allowed insurers to build up unnecessarily large reserves.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

MGMA/CRAHCA

The Integrated Health Care Puzzle

March 4-6, 1996

Denver, Colorado

(303) 397-7881

CRAHCA

14th Annual CRAHCA Conference: Integrated Delivery Systems

March 4-6, 1996

Denver, Colorado

(303) 397-7876

Qualife Cancer Veterans Workshop

March 8-9, 1996

Denver, Colorado

Contact: Myrna Bottone (303) 393-9355

American College of Cardiology

The 3rd Annual Echocardiography Workshop at Vail

March 26-29, 1996

Vail, Colorado

Contact: (800) 257-4739

Prosper Meniere Society

Annual Winter Meeting and the 5th Symposium on Inner Ear Medicine and Surgery

March 1996, Aspen, Colorado

Contact: Jane Wells or I. Kaufman Arenberg, MD

(303) 778-4235

MGMA/CRAHCA/ACMPE

The Essentials of Group Practice Management

March 25-27, 1996

Denver, Colorado

(303) 397-7876

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop

March 28-29, 1996

Englewood, Colorado

(303) 397-7876

MGMA/CRAHCA

PEER- Performance Efficiency Evaluation Report

Users Workshop

April 1-2, 1996

Englewood, Colorado

(303) 397-7876

Colorado Neurological Institute

Pediatric Neurology: A Course for Primary Care Providers

April 11-12, 1996

Keystone, Colorado

(303) 788-5006

Aids Medicine & Miracles

9th Annual Healing & Renewing Retreat

April 12-14, 1996

Denver, Colorado

Contact: 800-525-6651

American College of Cardiology

Clinical Cardiology Management and

Diagnostic Dilemmas

April 17-19, 1996

Santa Fe, New Mexico

15.5 Category 1 AMA CME credits

(800) 257-4739

American College of Cardiology

Cardiology Fiesta in San Antonio: Update on Cardiac Diagnostic and Therapeutic Techniques

April 25-57, 1996

San Antonio, Texas

17.5 Category 1 AMA CME credits

(800) 257-4739

AMC Cancer Research Center

15th Annual Day of Caring

April 29, 1996

Hyatt Regency Tech Center, Denver, Colorado

Contact: Christine Conway

Medical Records Institute

Toward an Electronic Patient Record '96 Conference

May 11-18, 1996

San Diego, California

Contact: Kimberly Allen (617) 964-3923

CMS Med Fax

MGMA/CRAHCA

7th Annual Conference of Administrators in Oncology/Hematology Assembly
May 15-17, 1996
Denver, Colorado
(303) 397-7876

Colorado Medical Society

Leadership Conference
May 18-19, 1996

Beaver Run Resort, Breckenridge, Colorado
Contact: Sandy Finney (303) 779-5455 Ext. 2406

International Meniere's Disease Research Institute

9th Annual Electrocochleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar
Summer 1996, Denver, Colorado
AMA and ASHA CEU's offered
Contact: Jane Wells or I. Kaufman Arenberg, MD
(303) 778-4235

Society for Computer Applications in Radiology

Symposium in Computer Assisted Radiology
June 6-9, 1996
Denver, Colorado
(703) 716-7548

American Medical Association

Organized Medical Staff Section(AMA-OMSS)
27th Annual Meeting
June 20-24, 1996
Chicago, Illinois
(800) 262-3211

Colorado Society of Osteopathic Medicine

Annual Meeting
June 21-23, 1996
Manor Vail Lodge, Vail, Colorado
18 hours AOA category 1-A CME credits, FP and Physician Assistants credits
Contact: Patricia Ellis (303) 332-1752

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
June 27-28, 1996
Englewood, Colorado
(303) 397-7876

American Psychiatric Association

Dynamic Psychotherapy in the New Era

July 29-August 2, 1996
Aspen, Colorado
18 Hours CME Credit, Category 1
Contact: Maria Gorrick (202) 682-6145

American College of Cardiology

Echocardiographic Symposium on 2-D and Doppler Echocardiography
July 29-August 1, 1996
Vail, Colorado
23 Category 1 AMA
(800) 253-4636

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
August 22-23, 1996
Englewood, Colorado
(303) 397-7876

Colorado Commision on Family Medicine

1996 Opportunities Fair and Annual Conference
September 6-8, 1996
Copper Mountain Resort, Colorado
(303) 745-4275

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
November 7-8, 1996
Englewood, Colorado
(303) 397-7876

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
December 5-6, 1996
Englewood, Colorado
(303) 397-7876

International Meniere's Disease Research Institute

8th Annual Interdisciplinary Seminar on Diagnostic Rehabilitative Aspects of Dizziness and Balance Disorders
December 1996, Denver, Colorado
AMA and ASHA, PT and Nursing CEUs offered
Contact: Jane Wells or I. Kaufman Arenberg, MD
(303) 778-4235

PRESIDENT'S LETTER



*Joel M. Karlin, MD
President, 1995-1996*



In 1994, following a Colorado Medical Society Board of Directors meeting, a fellow Board member shared with me his sense of resignation and anger over what was happening to patients and physicians in this increasingly HMO-dominated market. He related issue after issue which compromised his ability to provide quality care to his patients. He was furious that nobody cared anymore about what the patient wanted or what was best for the patient, and he sensed that HMOs were going to take away his ability to practice medicine unless he and other physicians learned to "walk and talk the party line". It was easy to relate, after having experienced the same feelings of depression, despair, and anger when my own practice was "terminated without cause" from a large HMO the previous year. At that time, all available resources to assist the plight of my patients and practice had been investigated, but to no avail. I believed the pendulum would begin to swing back the other way only when policymakers themselves became personally impacted by the ways of "bad" managed care, and the physicians themselves became part of the solution, instead of being part of the problem.

In my Presidential address to the CMS House of Delegates Annual Meeting I expressed my deep concern over the loss of this valuable doctor-patient relationship. The patients, the lost part of the current health care delivery system, have become powerless when they must rely on the employer's choice of a health care plan. Most often, the

employer's decision is driven by the amount of the monthly premium. But lower premium cost translates into more tightly controlled HMOs where patients lose choice of physician and physicians are coerced into practicing "company" medicine. Patients are then forced to choose a physician from a preselected roster. Eighteen percent of patients in the U.S. change their primary care physician each year. That vulnerable patient walks into a strange doctor's office hoping that the physician's first duty will be to act as the patient's advocate and do what is best for the patient. They hope that the physician has taken and believes in the Hippocratic Oath, even though they may not know what that means.

Three months ago, CMS was made aware of managed care contracts which prevented the physician from always speaking as the advocate of their patient. An Aurora internist brought us an IPA contract which required the physician to present to the public a positive image of the IPA, IPA physicians and the plans which are parties to IPA agreements. This was a contractual obligation which was continued into perpetuity, even though the agreement might be terminated. In this light, if you were asked by your patient to counsel them on the selection of health plans, and each plan or contracting organization's agreement contained such language, you would be contractually obligated to speak in a "positive" manner about each plan. Is that ethically acceptable to both you and your patient?

The pendulum begins to swing the other way!

Before determining what our response should be, we contacted many of the HMOs inquiring whether such 'gag' provisions were contained in their contracts. With the exception of two, all HMOs denied they would even consider such restriction on patient-physician communication. Those two agreed to eliminate the offensive language. It didn't appear at the time that we had a real problem. But before dismissing the issue, we decided to look at several HMO contracts ourselves. Here's a sample of the contractual language we found: "Plan and Provider and their employees and agents shall discuss and represent their contractual relationship with Members in a positive and professional manner. Issues or difficulties regarding the contractual relationship shall be discussed only between the parties of this agreement." The implications are astounding! If you request pre-authorization for a procedure which you believe is needed by your patient, and the plan turns you down, you cannot then speak other than in a positive way to your patient about that decision. Or if your patient requires care which is best provided by a physician or an institution outside the plan, you cannot even inform your patient of that option.

PRESIDENT'S LETTER

(Continued)

The straw which broke the camel's back came in the form of a telephone call from a primary care physician in Arvada. During the first week of January he received a letter of "termination without cause" from a large Colorado HMO (let's call them "Friendly HMO"). The following week a letter came from his contracting physician organization to notify him that their Board had just been informed that his termination "comes as a direct result of allegations or defamatory comments made to "Friendly HMO" members regarding their health plan (specifically those members associated with capitated plans through the physician organization). After requesting his side of the controversy within two weeks, the letter went on to "serve as official notification that the physician organization's Board of Directors is placing his membership in their organization under immediate review". What could that physician have said to his patient to prompt such an action? In discussing the particulars with the physician and two of his patients, it became clear that he had simply answered questions from his patients in an open and truthful way. The plan had been marketed to them as providing excellent benefits with a very low monthly premium cost without mention of the many restrictions.

Within days, CMS staff assembled information from the American Medical Association and other states regarding possible legislative solutions to "gag" rules, and over a weekend staff began writing HB1216, concerning the prohibition of provisions in insurance carriers' contracts with their participating health care providers. Two legislators who have always shown great concern for patient welfare, Representative Martha Kreutz and Senator Sally Hopper, agreed to sponsor the bill. This bill requires that all contracts between a carrier and a provider or provider intermediary contain the following:

(A) The contract shall contain a

provision which states that the provider shall not be prohibited from protesting or expressing disagreement with a medical decision, policy, or practice of the carrier;

(B) The contract shall contain a provision which states that the carrier shall not terminate a provider because the provider expresses disagreement with a plan's decision to deny or limit benefits to a covered person, or because the provider assists the covered person to seek a reconsideration of the plan's decision, or because a provider has communicated with one or more of his or her current, former, or prospective patients regarding the provisions, terms, or requirements of the carrier's products as they relate to the needs of those patients.

Our bill was assigned to the House Business Affairs & Labor Committee. We worked closely with the CMS contract lobbyist, Jerry Johnson, in contacting committee members, and orchestrated our committee presentation. I spoke with Al Knight, editor of the "Perspective" section of the Denver Post about the importance of the issue. He published an editorial (the day before the committee hearing) entitled "Free Speech is for Doctors, too". (A copy of his editorial is included here.)

During the four hours we waited to testify, it became clear to all parties that we had the votes to pass our bill. A representative of the HMOs asked if we would be willing to have the joint CMS/CHMO Committee discuss this issue instead of legislating it. The answer was "No". Would we be willing to discuss objectionable parts of the bill with them? I answered that we are always willing to talk. We listened to their concerns. We were not willing to eliminate the language about "termination", but we were open to discussing their concern about true slander and bad mouthing by a physician against a health plan. That meeting ended with an agreement to work further on such language if our bill got out of committee.

What followed next made all the

hours I have spent as president very meaningful. At 7:30 pm, the House Business Affairs & Labor Committee began hearing HB 1216. Rep. Kreutz opened the testimony with her concerns about the problem. Dr. Eugene Sherman, Chair of the CMS Managed Care Task Force, and I presented testimony on behalf of CMS to clarify the problems which the bill addresses. The "disaffiliated" Arvada primary care physician and two of his patients were strong witnesses. Consumer advocates and a medical ethicist completed the presentation. Interestingly, the HMOs tried to convince the committee that the scope of the bill was too broad, that the bill intervered with "voluntary" contractual provisions which the physician did not have to sign, and that the legislature would be setting a bad precedent by interfering with "employment" contracts. What occurred next was heart-warming. Committee members related their "personal" experiences with HMOs. In the end, HB1216 was passed out of committee by an 11-1 vote!

We cannot rest now. That was only one of many steps which will be required before our bill becomes law. But it is an important step. The overwhelming vote in favor of the bill, particularly by this business-oriented committee, is a sign to managed care that the days of free reign over our health care delivery system without accountability may be coming to an end. It may be time for their industry to create and pledge allegiance to an HMO version of the Hippocratic Oath, putting the patient's welfare first.

And now I must ask for **your help**. We urge every physician in Colorado to contact their state legislators, particularly in the Senate. Tell them why it is important, for patients and for the future of our health care delivery system, for them to vote for HB 1216. Even if you cannot speak directly to them, leave your message. Following this article is a reprint of the "**Patient-Physician Covenant**", from the May 17, 1995 issue of the Journal of the American Medical Association (JAMA). Read it

carefully. I believe it embodies what is good about our profession, and a standard we must fight to preserve. Send a copy to your legislators.

As I believed two years ago and still do, when policymakers begin to feel the personal effects of HMOs, that is when physicians will have an opportunity to make changes for the benefit of our patients. I believe that time is now! The window of opportunity, however, is small so help me--and your patients--to push that pendulum back the other way.

Ask your legislator today to support HB 1216!

Reprint from:

JAMA, May 17, 1996-Vol 273, No. 19
Policy Perspectives 1553

Patient-Physician Covenant

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimization of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, carer, helper, and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity-one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gatekeepers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of

Free speech is for doctors, too

A recent issue of *Time* magazine featured an unusual picture of a doctor with a gag in his mouth. As the cover article went on to explain, the doctor was prevented by contractual arrangements with a health maintenance organization (Health Net) from sharing important—even vital—information with a patient.

Time's example was an extreme case, but all across the country doctors are beginning to complain that the growth of managed care plans (more than 50 million Americans at last count) has put physicians in an ethical bind. In extreme cases it has driven wedge between doctors and patients. Contracts both threaten and entice physicians. They threaten doctors with summary dismissal. By providing bonuses or payments, they sometimes invite doctors to advance their own personal and financial interests over those of the patients. This occurs when care is denied and doctors are told to avoid discussion of the very HMO policies that required them to deny it.

In the past month alone, campaigns have been started in Virginia, Missouri, New York, Colorado, Washington, Georgia and other states to limit the power of HMOs to restrict the flow of information between patients and doctors. The Colorado bill, HB 1216, gets its initial hearing before the House State Affairs Committee tomorrow. The bill is supported by the Colorado Medical Society and its president, Dr. Joel Karlin.

Karlin, in an interview this week, said he expects a number of doctors to come forward and describe their experience with contracts that effectively gag doctors and prevent them from either advocating for specific health services or discussing the HMOs limitations with patients. The bill would specifically prevent the insurance carrier from punishing a doctor who has "communicated in good faith with one or more of his or her current, former or prospective patients regarding the provisions, terms or requirements of the carrier's products as they relate to the needs of those patients."

Never mind the "good faith" condition, some HMOs will oppose the legislation. They are, after all, in a very competitive situation, signing physician contracts right and left, and the last thing they want is for there to be an uncontrolled discussion between doctors and patients about the merits of various

health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

Ralph Crawshaw, MD
David E. Rogers, MD
Edmund D. Pellegrino, MD
Roger J. Bulger, MD
George D. Lundberg, MD
Lonnier R. Bristow, MD
Christine K. Cassel, MD
Jeremiah A. Barondess, MD



**AL
KNIGHT**

plans as it relates to the particular needs of a patient.

The HMOs that can present themselves as offering the best service at the lowest prices (some plans are going for under \$100 a month) get the business in today's cost-conscious marketplace. Any discussion of how a specific

plan limits service, restricts continuity of care, cuts off specialized care or reduces frequency of treatment may cause customers to look around for a better deal.

The HMOs that have the best reputations and the lowest rates will get most of the new customers. Restrictive contracts with doctors are simply one way to keep negative comments to a minimum and to give the HMOs maximum latitude in finding the "right physicians."

As a result physicians find themselves in fast-changing circumstances. Primary care doctors often work for a variety of carriers. If one or more of these carriers become upset with a doctor they can yank their business, and the physician may find himself crosswise with not only the HMO but with the independent practice association to which he or she belongs.

The fact that the doctors are looking to the legislature for help means their individual and collective efforts at negotiating more favorable contracts have failed.

The legislature should listen closely to their stories but be thinking about the interests of patients, as well. No one is going to stop the push to managed care. It promises to reduce rapidly rising medical costs, and few people are against that.

What sensible people oppose is not managed care but having to choose a medical plan in the dark. Every patient, whether well or ill, has a basic right to information that will allow informed decisionmaking. That means he or she should be able to talk to anyone they want, including—no, make that especially including—their doctor.

Al Knight, editor of *The Post's Perspective Section*, can be reached at alatpost@aol.com.

Dr Crawshaw is in private practice in Portland, Ore; Dr Rogers, who died December 5, 1994, was the Walsh McDermott University Professor of Medicine at the New York Hospital-Cornell Medical Center; Dr Pellegrino is Director, Center for Clinical Bioethics, Georgetown University Medical Center, Washington, DC; Dr Bulger is President, Association of Academic Health Centers, Washington, DC; Dr Lundberg is Editor, *JAMA*, Chicago, Ill; Dr Bristow is President, American Medical Association, Chicago, Ill; Dr Cassel is Section Chief, Department of Internal Medicine, University of Chicago, Chicago, Ill; and Dr Barondess is President, New York Academy of Medicine, New York, NY

Women in Medicine Section Leadership Conference 1996



"Women Empowering Women"

The Women in Medicine Section (WIM) of the Colorado Medical Society provides a means for women physicians to network and participate in organized medicine. In 1995 WIM organized a conference to address issues of importance to women physicians. With over 130 attendees, the conference was a huge success. This year's conference, to be held at the Embassy Suites Hotel in Englewood on April 20, 1996, will be even better. Free on-site child care will be provided by the Thomas Learning Center.

The keynote speaker will be Dr. Linda Hawes-Clever, an internist from California and the editor of the *Western Journal of Medicine*.

After the keynote speaker, the following five workshops are planned:

- **Medical Marriages:** The purpose of this workshop is to introduce, discuss, and seek solutions to the challenges that arise when one or both partner(s) in a marriage is a doctor. A panel of four physicians and their spouses will participate. Susan Heitler, Ph.D., an expert in conflict resolution, will moderate this workshop.
- **The Glass Ceiling:** Harvard psychiatrist Sharyn Lenhart, MD, will explore the obstacles women encounter when advancing in careers traditionally dominated by men.
- **Impact of Careers on Children:** Helen Bucksbaum, Ph.D., will examine the challenges professional parents face when raising their children.
- **Team Management:** Les Wallace, Ph.D., founder and president of Signature Resources – an international management consulting firm – will explore ways to enhance productivity and satisfaction in the workplace by creating a team environment. His style of management utilizes proactive, coaching techniques.
- **Effective Speaking Skills:** Dennis Phillips, Ph.D., Associate Professor of Speech Communications at Colorado State University, will lead this workshop. Participants will have three to five minute speeches videotaped and analyzed by Dr. Phillips.

This conference promises to be an empowering experience for all participants. Please mark your calendars and watch for the upcoming flyer with more details and registration information, or call Cindy Wooley at 930-0419.

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



1996 promises to be a better year for physicians. Witness the fact that our leadership position on a number of critical legislative issues has held firm and, though we had to compromise on some, these positions will serve the medical community well. Patients, too, have something to gain in each issue. Take SB 148, the "Peer Review" bill: allowing access by outside persons to physician records concerning specific incidents or allegations involving quality or appropriateness of care. The patient stands to lose under this process because the doctor-patient relationship becomes an empty shell; the process of peer review would remain, but few persons would bother to use it. CMS killed the bill in committee. Yes, the defeat of SB 148 was a **big plus** for the patient.

What else? Well, there's the "Doctor Gag Bill", HB 1216. We managed to get it out of the Business Affairs & Labor Committee with an 11-1 vote as amended by the CMS. It goes to the House Appropriations Committee next. We don't know what'll happen, but at least we gave it a powerful send-off in the face of a lot of opposition by the state HMOs.

This legislative session has turned into a busy one, principally because CMS President Joel Karlin has been a very pro-active voice. He's been there to testify; he's written articles; he's written editorials, letters to the editor and has talked in person to many. He's willingly packed a bag and hit the road in support of the CMS position and, guess what? It's paying off! Scarcely a day goes by that we don't

see a reaction of some sort in the daily news, some negative, but mostly supportive.

Nowadays, "doctoring" involves a heavy dose of just this kind of determination and behavior. For centuries, physicians have not been compromisers; they have faced their enemies of infection, illness, pain and death, unwilling to compromise. **Their patients didn't want them to, ever!** They've been their patient's advocate. They still are!

Ever since the days he was Chief of Staff for then-Governor Dick Lamm, Colorado Governor Roy Romer has been determined that the Executive Director of the Colorado Department of Health should not be an MD (as required by state statute). Since he's been in the catbird seat, he's become fixed on this issue. This year, Colorado Medical Society Board of Directors elected to work toward a compromise with the Governor, and we achieved just that: a compromise!

The proposed legislation states that the Governor can appoint the now "acting director" (Pattie Shwayder) to Director, but will also have to appoint a physician as Chief Medical Officer who will have direct communication with the Governor and his staff. There are specifics as to training, experience, etc. No, it is not the same thing as having a physician as Director, but it is a valid compromise, considering the political climate enshrouding everything medical. I am proud that CMS stuck to its position and was able and willing to find a compromise. I believe it will work for the good of all concerned.

"Since he's been in the catbird seat. . ."

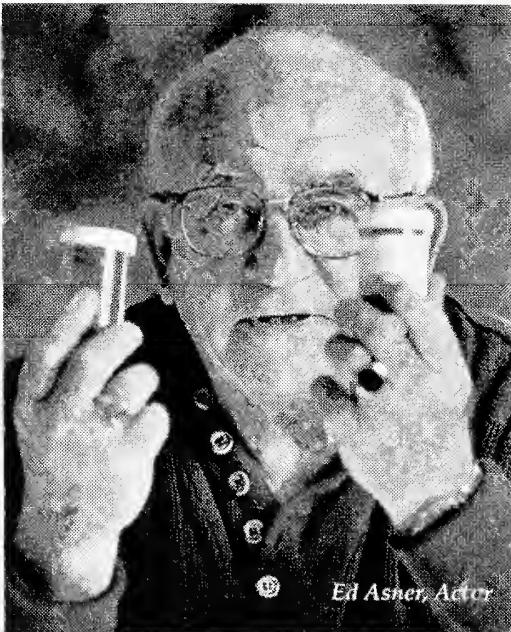
Recently, physicians have been hauled on the public block pretty frequently, but they keep fighting for their patients and their profession. I am proud of what CMS members have been doing on behalf of their fellow physicians and allied professionals in the health care industry. Physicians are about to get hauled on the block again, unless they are willing to act first. There's been a hue and cry for **"physician-specific data"** for many months. This has been kicked around like a football but we've finally got it on our home field: Effective March 30, 1996,

"Doctor's Day", CMS is commencing a statewide public education campaign to help physicians get the info to their patients. It isn't necessary that we should have legislation, managed care operators, HMOs, or any other special interest group telling us what and how.

And what about **"Doctor's Day?"** There couldn't be a better day to start this campaign! It's a patient advocacy, patient education issue.

I urge you to participate when you receive the doctor-profile form from Gadian Corporation. If you have questions about this, read the special feature in this issue of *Colorado Medicine* about it.

Attention: Physicians



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

Mail to:

 NCPIE

 666 Eleventh Street, NW
Suite 810
Washington, DC 20001

OR FAX:
(202)638-0773



*Richard Allen, MD, Chairman
Council on Legislation*

Things have heated up so much on the legislative front, that the Council on Legislation held its most recent regular meeting at the Capitol so that members could be readily available to testify on the myriad of bills now being heard. Much of the legislation that the Colorado Medical Society has been actively tracking has already passed through Senate and House hearings. Once again an excellent track record has been established, thanks to great support by CMS members and lots of hard work by leadership and staff.

HB 1073, the Rural Health bill which provides incentives for physicians to practice in rural areas, has just passed out of the Finance Committee and is now on the way to the Appropriations Committee. The tax credit portion of the bill has been removed, however the loan repayment plan is still in tact. The Council is confident that this bill will pass.

The Governor's proposal to remove the requirement that a physician be the State Public Health Director, **HB 1125**, is still in the works. CMS is not supporting this bill. However, because of recent negotiations between CMS Executive Director Sandra Maloney and Alan Weil of the Office of Health Policy and Financing, compromise language has been proposed. If this compromise language and attached amendments are instituted, then CMS leadership believes that an acceptable arrangement will have been reached and will therefore not oppose the bill. **HB 1125** must still go before the House Health, Education, Welfare and Institutions (HEWI) Committee where a fiscal note will

probably be attached.

HB 1216, the "gag rule" bill has also been a high priority item. This bill prohibits HMOs from placing language in their contracts with physicians which would explicitly or implicitly disaffiliate a physician for advocating appropriate care for patients. The "gag rule" has been the same sort of public relations nightmare for the HMOs as was the drive-through delivery issue. HMOs claim that the gag rules were instituted to prevent doctors from stating derogatory comments about a plan. CMS does not condone the use of defamatory remarks by physicians, however prohibiting physician powers to practice medicine violates both the Hippocratic Oath and CMS policy. While the HMO industry claims that they do not enforce gag rules, the Society has anecdotal evidence which sustains the fact that physicians have been removed from panels without cause for speaking out against a carrier.

Any of you with a January 22, 1996 issue of *Time* magazine should read the cover article entitled "What Your Doctor Can't Tell You". **HB 1216** successfully passed through the Business Affairs & Labor Committee and is now headed for the Appropriations Committee.

With CMS support, Senator Hopper has introduced **SB 112**, which would authorize the collection of data regarding the Health Care Professional Work Force. This bill would establish a method for the Director of the Division of Registrations to collect data and allow state agencies access to that data. An important provision in the bill

"This critical stage in the legislative effort is quickly approaching. . ."

guarantees that no information specifying a professional's identity appear in any public report. **SB 112** passed Senate HEWI and has now been referred to Appropriations.

Another major victory came when **SB 148** was killed in committee. The trial lawyers introduced this bill which would have allowed access to professional review records.

Currently there are approximately 30 bills which the Council on Legislation is tracking. All of these bills are in various stages of review. The best way to get an up-to-date reading on any bill is to contact the Department of Government Relations at CMS.

Next month committee work will be finishing up and bills will be on the floor for second readings. This critical stage in the legislative effort is quickly approaching, and CMS will undoubtedly need to call on many of you to help as key contacts.

Call for Nominations

The Secretary of the Colorado Medical Society (Executive Director, Sandra L. Maloney) has announced a ***Call for Nominations*** for the following offices of the Colorado Medical Society:

President-elect

Vice Speaker of the House of Delegates

AMA Delegate

AMA Alternate Delegate.

The CMS Nominating Committee will meet during the Interim Meeting of the House of Delegates, March 23-24, 1996, to hear from those persons expressing an interest in being nominated for the above offices.

HIGHLIGHTS OF CMS BOARD OF DIRECTORS MEETING -February 9, 1996

Topic:

Copic CEO Dr. Jerome Buckley, gave a brief presentation on the dislocation of physicians in managed care. He thanked CMS for the invitations to Mary Lee Johnston's retirement party, and congratulated CMS on its current membership numbers.

Colorado Physician Network:

David C. Martz, MD, presented an update on the Colorado Physician Network, which still needs about 500 additional primary care physicians to be more representative of patients' needs.

Council on Legislation:

Dr. Richard Allen and Ms. Lorraine Koehn presented an update on various legislative bills. The Board ratified the recommendations of the Council on Legislation.

Consultant Services:

Dr. Truitt explained what is being done on physician profiling and outcome studies. Dr. Karlin commended Dr. Truitt on the work he has been doing.

Next Meeting:

The next meeting of the Board of Directors will be on Friday, March 22, 1996, at 2:00 p.m. at the Colorado Medical Society offices, 7800 E. Dorado Place, Greenwood Village.



Physician Hospital Organizations: A viable strategy?

Virtually every hospital in the country has formed, or is forming, a physician hospital organization ("PHO"). Whether this is a benefit to hospitals and physicians is still an open question addressed in the following articles:

Julie Johnsson "Are PHOs ready to cope with managed care?" American Medical News, p. 30, February 27, 1995.

Sidney Stevens, "Rosy Outlook Turning Grim for Many PHOs, Groups Without Walls," Physicians Financial News, p. 1, June 15, 1995.

Mary Chris Jaklevic, "PHOs fall short of expectations", Modern Healthcare, pp 77-82, October 9, 1995.

The key is that simply forming an organization is not enough. To manage care and to manage risk requires expensive infrastructure, as pointed out in the following articles:

Ken Terry, "Super-PHOS: Super path to a larger market share?" Medical Economics, pp. 142-150, September 11, 1995.

Pamela Taulbee, "Experts Caution PHOs To Focus on Utilization, Infrastructure," Report On Physician Trends, p. 1, February, 1995.

Pamela Taulbee, "Follow These Steps, Avoid These Pitfalls In Developing A Super PHO," Report On Physician Trends, p. 4, March, 1995.

Why should you go through heartburn of forming a PHO? So that you may win contracts, take on risk and manage health care quality and costs, of course.

Clark W. Bell, "Providers should weigh risks of risk assumption" Modern Healthcare, p. 34, January 29, 1996.

"The Game of Risk: Providers are fighting back. Fuming over HMOs' high margins and lower payments, they are negotiating full-risk contracts," Modern Healthcare, pp 24-29, February 5, 1996.

However, it may not be as simple as it seems.

Julie Johnsson, "Feds take aim at PHOs: IRS ruling could leave doctors facing more risks than benefits," American Medical News, P. 1, January 23/30, 1995.

Thomas O. Katz and Mark A. Coel, "Medical Networks Raise Physician Liability Issues," The National Law Journal, p. B13, April 24, 1995.

Max Mitka, "Insurance commissioners eye model PHO regulations," American Medical News, p. 5, June 26, 1995.

Brian McCormick, "Firing a warning on PHOs: Antitrust settlements a 'shot across the bow' by feds." American Medical News, p. 3, October 2, 1995.

If you can't find the articles in your hospital medical library, the Colorado Medical Society can FAX them to you. Call Lorraine Heth at (303) 930-0409 or 1-800-654-5653 Ext. 2409.

Leigh Truitt, MD

CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



If I don't pay ... Do I have any say?

As horizontal and vertical integration occurs, many physicians have contacted Copic to advise them on their medical liability insurance coverage. Some physicians plan to become employees of a "system" and their liability insurance will be provided to them. Others may join an IPA (single specialty or multi-specialty) under an exclusive contract which gives the IPA the responsibility and right to choose liability coverage. In either case, the physicians will not be directly paying for their insurance. They may have concerns about the carrier and coverage provisions. These are valid concerns; several of our insureds have already experienced this situation.

As with any "benefit", you may not be the decision maker but you certainly are a stakeholder. You first need to carefully read your contract, be it employment or otherwise, to know who has the responsibility and the authority for your liability coverage. It is critical to know whether or not tail coverage will be your responsibility or whether what is known as nose coverage (prior acts) will be purchased for you as part of the contract.

You certainly need to know what companies are being considered and how the process works. If you have

had a great experience with your current liability carrier regarding the type of coverage, the risk management, educational and service aspects as well as price, you should put forth a strong effort to have that company at least be included in the bidding process.

". . . you certainly should make your wishes, concerns and preferences known."

Often you may find that the corporate purchaser acting on your behalf is not aware of your concerns. Treating your medical liability insurance as a commodity, the purchaser has contracted with someone else such as a broker agent to purchase the commodity for them (and you) at the best price. Many corporate purchasers or decision makers would welcome your input, especially if this is an important issue to you--and it should be. No employer or contractor wishes to start out the relationship on an unhappy note; communicating your wishes as well as concerns would likely be well received.

Prior to sending out a request for proposal to prospective carriers, broker agents request information concerning a physician's insurance and claims history from the current carrier. It is important for you to know that Copic will not release this type of information, even to a designated negotiating agent, without written permission of the insured. Because of Copic's stance on this issue, Copic could be viewed as "difficult to work with".

Copic is committed to work for our insureds and is willing to compare policies for coverage issues--to make sure that what you are being offered is what you presently have or to point out what differences exist. Copic also is willing to do everything possible to continue to represent you and, if given the opportunity, will be very competitive. Even though you may not be the payor, you certainly should make your wishes, concerns and preferences known. As a physician directed and locally domiciled professional liability carrier we believe we remain positioned as the only carrier to best serve the interests of Colorado physicians.

If you like what we've heard in the Primaries . . .

you'll love what's going to happen in November. Where does Colorado fit in? Your membership in COMPAC will assist with financing the campaign of Colorado legislators who are supportive of medical practice issues and who can have a positive influence on Washington. 1996 is already another critical legislative year to medicine, so help however you can. JOIN COMPAC NOW!



Doctor, if you're thinking about retirement, have you thought about protecting yourself from unexpected medical costs?

Mergers, acquisitions, capitation, regulation, the change keeps coming. New laws, increased costs, decreased profits, managed care, tougher government regulations, heightened competition... many physicians are reviewing their retirement plans with increased interest. Have you been asking yourself "How long before I can retire?" Or "Can I retire now?" If you have, there is some vital information you should have, quickly, to avoid any disruption.

You have probably tried to incorporate every asset protection "device" into your retirement program to assure yourself that distribution of your assets will occur as you have planned. Over the past nine years, our company has found many professionals (and their financial planner/attorney) have overlooked a very important aspect of their retirement plan: will it allow you to pay out \$36,000 (or more) per year in unexpected medical care which is generally not covered by your individual medical plan? Or medical expenses which Medicare will not cover? A giant outlay when you are not prepared for it!

Our company specializes in working with individuals, providing private consultations in your home or office. We can also work directly with your attorney/financial planner, to review protection from this potential large unplanned expenditure. We also have provided educational seminars for special interest groups, corporations and government entities on the topic of insuring against such financial despair.

If you would like to learn more about this possible expenditure, how it affects you and how to protect yourself against its damages, please call me. Our office number is 303-697-8988; or if you are outside the area, dial 1-800-788-8205. Call me today.

Thank you for your interest.

Eunice E. Krieger
President
KRIEGER & ASSOCIATES, INC.



The Time is Now: Evolution of CMS

by M. Ray Painter, MD
President-Elect
Colorado Medical Society



"It is imperative that we figure out how CMS can better support physician members, patients and service providers."

Times they are achangin'! Physicians have never faced the magnitude of changes that we are experiencing today. A combination of emphasis on cost control, profiteering from managed care, contract medicine and new technology – in both the practice of medicine as well as informatics – has created a transformation in the way physicians think and function.

As with the practice of medicine, organized medicine must also evolve. Some say, "If it ain't broke, don't fix it." While CMS "ain't broke," I believe that we cannot face the myriad of challenges in medicine today by maintaining the status quo. For the past decade I have watched these changes. Over and over again my thoughts have returned to two problems that I see facing CMS; the first is a long-standing problem and the second is unfolding.

Problem #1 – CMS has always had two separate mission statements: patient advocacy and physician advocacy. As could be expected, this purpose has at times been the figurative equivalent of serving two different masters. Physician advocacy has consistently been labeled as self-serving and consequently that "self-serving" label has hurt our "patient advocacy" mission.

Problem #2 – As the profession diversifies, the fiscal trends associated with the practice of medicine have created different pressures on how physicians can earn an income. Many physicians are still practicing in their private offices, others are in group practices, and still others are under contract with managed care companies. These physicians may need support on the business side of medicine. On the opposite end of the spectrum, many other physicians are salaried administrators and have totally separate sets of needs. There are also numerous categories in-between.

The time is now to address these problems. It is imperative that we figure out how CMS can better support physician members and patients.

On February 8, 1996 I sent out a packet to all the component society presidents, MEGS and the CMS Board of Directors requesting assistance in this process. I asked them to appoint a task force to explore the evolution issue. I also asked them to join me at the **Leadership Conference** in Breckenridge at the Beaver Run Resort on May 18-19. I would like to extend that invitation to you. If you cannot

attend, please think about what CMS means to you, and how we as a society of physicians can evolve and flexibly respond to the needs of today and tomorrow. Here are some questions you might consider:

- Should CMS be separated into two different entities or functional segments to address physician and patient needs respectively?;
- Should a permanent physician C.E.O. or Executive Vice President of CMS be instituted?;
- Should the Board of Directors be reorganized? Paid?
- Should representation in the House of Delegates be re-organized into modes of practice, such as hospital physicians, University physicians, administrative physicians, etc? Or should special interest component societies be formed?
- Should presidential terms be extended?;
- Should new services be provided like contract review and evaluation of capitation levels?;
- What new methods of communication could be instituted to provide better networks of information, cooperation and coordination?;
- What can CMS do to help stop the fragmentation of medicine from within?

Please think about these issues, and **consider the big picture** now. We will work out the details later. Join me at the Leadership Conference in May, or talk to your colleagues and leadership. This is our mission. Together we can take CMS and the profession of medicine into the next century.



Outstanding Service by Physicians

“. . . they represent what Colorado Medical Society has stood for throughout its one-hundred, twenty-five years of service. . .”

Now is the time; this is the place; you are the one. . . maybe. Whatever the circumstances, you, as a member of the Colorado Medical Society, can nominate one of your colleagues or peers for an outstanding award. You are urged to look around you, see your fellow physicians with a warm but critical eye. It is a time in your professional life that you should appraise your peers for their service to community and to their professional group. Colorado Medical Society presents two such awards each year for just those areas of service.

The Wyeth-Ayerst Physician Community Service Award is given in recognition for an individual's activities for his/her community, outside the practice of medicine. Long known as the A. H. Robins Award for Community Service, this has been a coveted recognition. Wyeth-Ayerst Pharmaceuticals has continued the proud tradition of the

founder of the Robins Company after its merger with Wyeth. CMS has once again been invited to participate in this award. Now, it's your turn:

The Colorado Medical Society Certificate of Service may be given to a physician member or other person for outstanding contribution to the Constitutional purposes of the Society.

This is the highest award given by the Society. The recipient is chosen by the Confidential Awards Committee from nominations by the membership, then elected by the House of Delegates.

Indeed, these are small recognitions for exemplary service and contributions, but they are important and physicians and others should be recognized. We hope you will help. Such recognition in this year, the 125 Anniversary of the Colorado Medical Society, is even more important because these awards represent what Colorado Medical Society has stood for throughout its one-hundred and twenty-five years of service to Colorado physicians and citizens alike.

To nominate a fellow physician member of CMS for either award, contact your component medical society officers or staff or CMS Communications Division (800-654-5653 or 303-779-5455). Give them your nominee's name. Provide them with material or information to support the nomination, and ask that this nomination be forwarded to the CMS Confidential Awards Committee.

Here are the parameters:

1. The nominee must be a physician, licensed in Colorado.
2. The recipient must be living. Awards are **not** presented posthumously.
3. The recipient has not been a previous recipient of the Award.
4. The recipient has compiled an outstanding record of community service, which, apart from his/her specific identification as a physician, reflects well on the profession.

All nominations must be received by the Colorado Medical Society on or before **June 30, 1996**.

It is often said, "we learn from experience" and "history is an important teacher". This is certainly true in respect to the outstanding community and professional service of physicians in Colorado--from the early days in the gold and silver camps and mine shafts to the present-day doctors who are willing to take from their practice to help their own communities through ever-increasingly difficult socio-economic times. The days of the "house calls" may be gone, but humanitarian service by physicians is certainly not. We need to remind ourselves of that and to recognize those who go beyond their professional responsibilities.

Colorado Medical Society will appreciate your participation in this call for nominations. Remember, the deadline for nominations for either award is June 30, 1996!

Ethics:

by Robert D. McCartney, MD
Alternate Delegate to the
American Medical Association



Questions About Managed Care of the Elderly

"The foundation of the doctor-patient relationship is trust."

Managed care has produced many questions regarding the ethical treatment of the elderly. It is important to study the history of prepaid health care in order to understand the medical ethics that must govern such care. Dr. Nancy Jecker has carefully detailed the history of prepaid care starting with its birth in 1787 in fraternal organizations and mutual benefit associations.¹ In 1900 railroads, mining firms and the lumber industry introduced company doctors to deal with their job related injuries and to provide for general health care in remote rural areas. At this early time the AMA expressed concern about the quality of care and the impact of competition on fee-for-service physicians. The AMA did acknowledge the economic necessity of *contract care* in the rural areas.

In both 1907 and 1911 the AMA Judicial Council published reports in

JAMA denouncing contract practice, except in cases of economic necessity. Specifically identified was *lodge* practice, which had no economic excuse nor justification. The studies conclude that contract practice promotes ruinous competition among physicians, and that physicians cannot afford to give good service for the amount of reimbursement generally received under those circumstances.

In 1913 the AMA Judicial Council addressed the issue of disproportionate compensation in fee-for-service contract practices. The Council reported:

"The physician has himself to blame who, through failure to put a just appraisal on his services and to demand a just reward for them, and who, through failure of endeavor to collect his just desserts, finds himself unappreciated and unrewarded." Despite this caveat, most of medical practice remained fee-for-service.

In an attempt to solidify organized medicine's position on prepaid health care, the AMA Bureau of Medical Economics in 1934 reported that:

- All features of medical service in any method of medical practice should be under the control of the medical profession;
- No third party must be permitted to come between the patient and his physician in any medical relation;
- Patients must have absolute freedom to choose a duly qualified doctor of medicine;
- There should be no restrictions on treatment or prescribing not formulated and enforced by the

organized profession of medicine.

During the 1940's legislation and court decisions allowed big business to offer prepaid medical care. Moreover, there was also U.S. Supreme Court action against the AMA for coercion against a prepaid plan. Following World War II, prepaid health care went corporate with the appearance of Group Health of Puget Sound, Kaiser Permanente and Health Insurance Plan of New York.

In 1959 the AMA Commission on Medical Care Plans found no evidence of lay influence on medical decision-making in an investigation of prepaid plans. At that time, official AMA opposition to prepaid health care ceased.

Throughout this history of managed care the principle value of medical practice has been the *doctor-patient relationship*. Health experts agree that "the fundamental element of the doctor-patient relationship is patient advocacy, which should not be altered by the health care delivery system in which the physician practices."² Managed health care employs techniques of cost containment which may undermine this fundamental obligation of the physician. The foundation of the doctor patient relationship is *trust*. The Hippocratic Oath clearly defines elements of that trust in terms of:

- Confidentiality of the medical record;
- Avoidance of mischief;
- Avoidance of sexual misconduct;

(Continued)

- Prohibition of prescription of harmful or death-causing agents;
- Performance of only those services for which the physician is trained;
- Placing the physician's health at risk for the patient;
- Performance of everything in a physician's power to help the patient.

Trust is therefore an essential ingredient to the healing process. Trust in the principles of medical ethics is also the standard by which managed care techniques can be made that alleviate conflicts of interest for physicians.

Conflicts of interest that may influence the rate of utilization of medical services are intrinsic to medical practice. Examples include:

- *The needs of the individual versus needs of the practice:* In both fee-for-service and capitated health care, physicians have a conflict when it comes to triage; decisions must be made about which patients will receive services first and which patients will receive those services that are in short supply.
- *Provision of services that are of small or uncertain benefit:* It is unethical to knowingly provide unnecessary care. However, the extent to which a physician should remove all elements of uncertainty or render expensive treatments with little chance of benefit are still disputed.

Conflicts of interest rising from managed care must be adjudicated by the principles of medical ethics. Autonomy, justice, nonmaleficence and beneficence must act as the governing paradigm.

Critics of managed health care contend that the financial incentives of managed care lead to underutilization of services, thereby violating the principles of beneficence and nonmaleficence. While neither overutilization nor underutilization are in the patient's best interest, there is concern that *ageism* (the systematic bias against the elderly) increases the risk of underutilization in terms of delayed diagnosis and poor outcome.^{3,4,5,6}

There is also concern that the ethics of medicine will be replaced by the ethics of business. Such a premise assumes that:

- Physicians are competitors;
- Medical services are commodities;
- Patients are consumers;
- Consumer satisfaction is more important than delivery of needed care;
- The peer review process can be replaced by market forces.

These assumptions are flawed because they skirt the already established principle value of medical practice. The doctor-patient relationship must negate the incentive to undertreat in managed care because patient trust and satisfaction mitigate the delivery of needed care. Peer review also plays a vital role. If justice, nonmaleficence and beneficence govern managed care, then arguments which state that market forces will adjust for the potential adverse impacts of financial incentives to undertreat are moot.

"There is also concern that the ethics of medicine will be replaced by the ethics of business."

Critics of managed care also point to the constrained freedom of choice for patients in health plans as a violation of the principle of autonomy. Many experts considering the public release of physician specific data think that it will be of limited use to patients considering various health plans because patients do not know what health care services are important to them until they get sick. Proper autonomy can only come from the option to leave the plan at such a time to seek a qualified physician (if one does not exist within the plan).

Advocates of managed health care contend that the impact of restricted autonomy can be minimized through thorough disclosure of the plan structure and financial incentives for limitation of care and access to specialists. Debate continues over whether this disclosure is the responsibility of the health plan or the physician.

Advocates also claim that fee-for-service medicine has an incentive to overtreat and over-diagnose the patient. Health care specialist G.J. Agich relates, "Physicians clearly do not take vows of poverty; hence, their service commitments are intricately tied to their own economic self-interest."⁷

Indeed overutilization is not without hazard. Among patients over the age of 85 admitted to the hospital, adverse events occur in 35-50% of cases. Again, among the elderly 10% of all hospitalizations result from an adverse drug reaction.⁸

Other arguments in favor of managed care contend that:

- The fee-for-service model also does not serve patients well for those services that are poorly reimbursed, such as nursing home care;^{9,10}
- Because managed health care does not exclude any eligible beneficiary, HMOs afford greater access to care than does the fee-for-service model, thus better fulfilling the ethical principle of justice.
- Managed health care demands that physicians critically review their styles of practices and their standards of care, which will lead to a better practice pattern;
- Managed health care places an emphasis on low technology, care oriented treatments, which are often what elderly patients prefer;
- Better practice results when financially it is in the physician's best interest to seek appropriate advanced directives on all patients;
- The fee-for-service model can have devastating impacts on a family's finances, without a true appreciation by the patient of the value of the services received.

(Continued)

Indeed the degree to which financial incentives impact conflict of interest can be related to the methods of physician reimbursement.¹¹ Identified factors include:

- The percentage of the physician's income placed at risk;
- Frequency with which incentive payments were calculated;
- Size of the group for which economic performance is assessed and compared.

A gradation of incentive to underserve is defined as:

- Fee-for-service;
- Capitation of group with fee-for-service to individual physicians;
- Individual physician capitation;
- Capitation with bonus for group performance;
- Capitation with bonus for individual performance with entire population of patients;
- Capitation with bonus or withhold for performance with an individual patient.

Conclusion

When I first entered practice, an old mentor told me the *Four A's of Successful Practice*: 1) Availability;

2) Affordability; 3) Amiability; and 4) Ability. The *Four A's of Successful Practice* can continue to be words of wisdom in both traditional fee-for-service and managed care today.

Years ago, after listing the *Four A's* my mentor woefully concluded that the least considered of these is ability. That lamentation should not be heard again. The ethical foundation of a physician's ability to practice medicine rests in the doctor's professional allegiance to the patient to provide quality and cost effective care. From this foundation emerges a guide to the solutions to the ethical dilemmas we have been discussing:

- Quality care for patients is the culmination of advocacy and the trust imbued in the doctor-patient relationship. In the assessment of physician performance, quality rather than utilization must be the focus. To ensure this, physicians must be involved in the development, implementation and evaluation of data on performance. The use of this data must focus on educational, nonpunitive solutions. Physician care must be

evaluated in terms of only those elements within physician control. Data released to the public should not contain physician or patient identifiers;

- Financial risk must not compromise care. Physicians should assess their practices before entering into capitation to determine what their current capitation rate is under fee-for-service. Stop loss insurance must be available. Adequate numbers of patients must be enrolled to spread the risk of a catastrophic occurrence. Assistance can be carved out of specific services to adjust for increased severity in a case mix. The point of service option allows for accountability of the plan to the needs of the patient;
- Subspecialist should not be penalized for possessing additional training beyond general internal medicine. They should be able to provide principle care. To do otherwise interrupts the continuity of care and discriminates against the sicker patient.^{12,13,14,15}

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**Colorado Medical Society
1996 Interim Meeting Schedule**

To be held at the CMS offices

Friday, March 22, 1996

12:30 pm-1:00 pm	Finance Committee
2:00 pm -5:00 pm	Board of Directors

To be held at the Holiday Inn Southeast (Parker Road @ I-225)

Friday, March 22, 1996 -

6:30 pm-9:00 pm	Women in Medicine
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Saturday, March 23, 1996

6:30 am-5:00 pm	Registration
7:00 am-10:00 pm	Office open
7:00 am-8:00 am	Reference Committee Members
7:00 am-8:30 am	Nominating Committee Open Forum
8:00 am-8:30 am	Credentials Committee
8:30 am-9:00 am	House of Delegates - Opening Session
9:00 am-12:00 Noon	General Membership Meeting
12:15 pm-1:45 pm	Keynote: David Ginsberg Working Lunch featuring panel discussion with AMA President Lonnie Bristow, MD, and Drs. Barbara Reed, M. Ray Painter, Robert B. Sawyer, Charles Mains, and Jack Berry
2:00 pm-3:00 pm	Reference Committee Board of Directors/Constitution & Bylaws/ Credentials
3:00 pm-5:00 pm	Reference Committee on Health Affairs

Sunday, March 24, 1996

6:30 am-11:00 am	Registration
7:00 am-12:00 N	Office open
7:00 am-8:30 am	Arapahoe caucus
7:00 am-8:30 am	Aurora-Adams caucus
7:00 am-8:30 am	Boulder caucus
7:00 am-8:30 am	Clear Creek Valley caucus
7:00 am-8:30 am	Denver caucus
7:00 am-8:30 am	El Paso caucus
7:00 am-8:30 am	Larimer/Weld caucus
7:00 am-8:30 am	Pueblo/Western Slope caucus
8:15 am-8:30 am	Credentials Committee
8:30 am-10:00 am	House of Delegates - Closing Session
10:00 am-12:30 pm	State of the Society

*This portion goes
to CMS*

Interim Meeting Registration

1996 Interim Meeting of the Colorado Medical Society, March 23-24, 1996, Holiday Inn Southeast

Name (Please type or print) _____

Name of Spouse/Guest (if attending) _____

Component Society _____ Office Phone _____

RESERVATIONS FOR EVENTS AND MEETINGS

(Reservation deadline is March 7, 1996. Reservations accepted on a first-come, first-served basis)

Number of Reservations	Amount Enclosed
------------------------	-----------------

SATURDAY, MARCH 23, 1996

12:15 pm - 1:45 pm Luncheon

Complimentary

HOTEL RESERVATIONS

Please use the hotel reservation form below to make your reservations directly with the Holiday Inn Southeast. **The deadline for room reservations is March 8, 1996.** The preferred rate will be extended to CMS members on a space available basis after March 8.

MEETING REGISTRATION

Please submit a registration form by March 7, 1996, if you plan to attend this Interim Meeting. We're delighted to receive it by mail, fax, or phone. We can check you in more quickly and efficiently if you've preregistered, in addition to providing more accurate and therefore cost-saving guarantees for our food functions. Thanks!

MESSAGES

For your convenience, a message board will be provided at the CMS registration desk. The hotel's phone number is 303-695-1700. (You may want to leave this number with someone.) If you need to be contacted, ask the hotel operator to transfer the call to the CMS registration desk or CMS office.

WHAT TO DO

Complete this entire form and return it to Colorado Medical Society, by mail to: PO Box 17550, Denver, CO 80217-0550, by phone to: 303-779-5455 or 1-800-654-5653 or by FAX to: 303-771-8657.

*This portion goes
directly to the
hotel*

Hotel Reservation Form

Colorado Medical Society
Interim Meeting
March 23 - 24, 1996

Please Reserve _____ Rooms for _____ Person(s)

Name _____

Firm _____

Address _____

City/State _____ Zip _____

Will arrive on _____

Day _____ Date _____ Time _____

Will depart on _____

Day _____ Date _____ Time _____

Credit Card _____

Name _____ Number _____ Exp. Date _____

Type Room—

Single 1 person \$68

Double 1 Bed 2 persons \$68

Double 2 beds 2 persons \$68

Suite \$125

Extra Charge per person _____

No. Persons Adults _____

Children _____

Check One

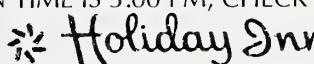
6 pm

Guaranteed

Estimated time of Arrival at Hotel _____ Sharing with _____

Current lodging tax is 11.8%. Group cutoff date is 3/8/96. Reservations will be held until 6:00 pm Denver time, unless accompanied by a first night's deposit or guarantee of payment to a major credit card (please include expiration date). CHECK IN TIME IS 3:00 PM, CHECK OUT TIME IS 12:00 NOON.

Return form to:

 Holiday Inn

Attn: Reservation Department
3200 S. Parker Rd.
Aurora CO 80014

**Or Call: 800-962-7672
FAX: 303-745-6958**



Cancer Control Plan for Colorado: How Many Lives Can Be Saved?

by Tim Byers, MD, MPH
Colorado Department of Health

Colorado's Cancer Control Plan sets out specific, achievable goals for reducing the future burden of cancer in Colorado. The plan is intended to reduce cancer mortality by achieving specified behavioral goals by the year 2000:

- Reducing smoking from 21.3% to 15%;
- Increasing the proportion of Coloradans eating five or more servings of fruits and vegetables per day from 21.5% to 50%;
- Increasing compliance with annual screening mammograms in women ages 50 and over; and
- Getting 60% of Coloradans ages 50 and over to have fecal occult blood screening.

This report uses a computer simulation to estimate the impact that achieving these goals might have on the numbers of Coloradans

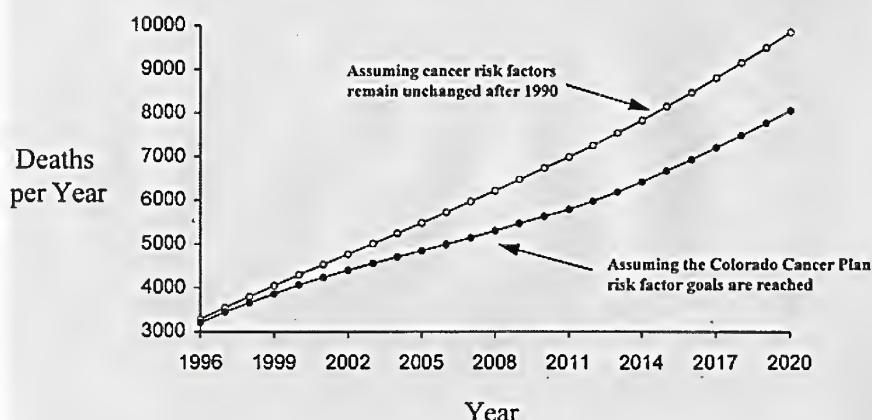
who will die from cancer over the next 25 years. Data on population projections, cancer rates and risk factor prevalences were taken from the Colorado Department of Health and Environment. Assumptions about the effects of risk factor changes and latency periods were based on published epidemiologic studies.

Over the next 25 years, nearly 160,000 Coloradans are expected to die from the four leading cancers – lung, colon, breast and prostate – if the 1990 Colorado cancer risk factor profile remains unchanged. However, if the above goals can be achieved by the year 2000, over 22,000 (approximately 14%) of these deaths will be avoided. The 22,000 lives saved may be an underestimate because of the conservative assumptions that are used. The latency

period before the full effect of tobacco cessation is realized causes the deaths prevented to increase substantially in the later years (Figure 1).

It is exciting to realize that the current efforts in Colorado to reduce smoking, improve diet and promote the early detection of cancer can result in the saving of so many lives from these four common cancers. Imagine McNichols Arena filled to capacity and 6,000 people waiting in line to enter and you can begin to understand how many deaths can be prevented. Continued efforts in both public policy and clinical practice can substantially reduce the future burden of cancer in Colorado. The goals of the Colorado Cancer Control Plan should be a high priority for action.

Future Cancer Deaths in Colorado* Under Two Different Scenarios



* Deaths per year from the four leading cancers: lung, colon, breast, and prostate



CMS ALLIANCE

Patti Brown, President
Colorado Medical Society Alliance



Stop America's Violence Everywhere (SAVE) Continues

The Stop America's Violence Everywhere (SAVE) campaign is an Alliance project. A friend mentioned to me that she had seen an article that credited the AMA with this project. SAVE was conceived by the AMA Alliance as a unifying health project for its component alliances. Each state and county alliance can devise and implement its own SAVE project.

In Colorado our project has manifested itself in many ways, as I have explained in previous articles. Chief among them was the "Don't Suffer in Silence" posters produced and distributed in the fall. The county alliances helped with the distribution of these posters, as did many physicians. Because of the high demand for them from various community sources, the CMS Alliance requested monetary help from CMS-ERF to fund an emergency printing for 200 additional posters. I wish to extend a big thank you to CMS-ERF for their help with this worthwhile project.

The community support for this project continues to pour in from numerous sources. Sonnie Talley, the current SAVE chairperson, has agreed to continue as the chairperson for next year, and has asked me to co-chair the project with her. If you have suggestions on how the Alliance can seek solutions to the problem of violence, please contact either of us. New ideas for the campaign, along with ways to fund them are always sought.



CMS Alliance President Patti Brown with the original SAVE poster, which will be duplicated, filling many requests into the new year and renewed campaign.

National Doctors' Day: Launch Day for the CMS "Physician Profile Project"

by Chet Seward, CMS Communications

March 30, 1996 marks the national observance of the Annual Doctors' Day. Communities have used this day to express gratitude for the contributions physicians have made for the sick, for the advances they have made in medical knowledge and for their dedicated leadership in improving public health.

President George Bush signed a proclamation establishing March 30 as "National Doctors' Day" in 1990. Governor Roy Romer followed suit the following year with a similar honorary proclamation in Colorado.

The first Doctors' Day was celebrated 63 years ago when the Barrow County Auxiliary commemorated the day in 1842 when Dr. Crawford W. Long first used ether anesthesia in surgery. The Auxiliary placed flowers on graves of deceased physicians and mailed letters to doctors and their wives.

Today, Doctors' Day has gained wide acceptance. Both nationally and locally communities recognize the day by organizing the donation of medical equipment and furniture to hospitals and nursing homes, creating scholarships for studies in health-related fields, delivering meals to the elderly, having blood drives and planting flowers or shrubbery in honor of physicians.

Physicians have been and continue to be **the patient advocate**. March 30, 1996 is an especially important Doctors' Day in Colorado because it marks the beginning of the Colorado Medical Society's **Physician Profile Project**.

In this age of health care reform and managed care, information is proving to be a vital commodity. As

the demand for access to physician-specific data continues to grow, it is critical for doctors to respond in a positive and proactive manner. In order to continue to be the patient advocate, physicians must be perceived as being cooperative in this area. By making accurate information available to patients, physicians all over Colorado can voluntarily demonstrate their dedicated leadership in providing quality care once again.

By making accurate information available to patients, Colorado physicians can voluntarily demonstrate their dedicated leadership in providing quality care.

The **Physician Profile Project** was created in response to a resolution heard at the 1995 CMS Annual Meeting. The information provided by the project will not try to document outcomes data for individual physicians because a reliable and valid means of obtaining that data does not exist, yet. However, the data will provide valid information on individual physicians. CMS encourages public access to data concerning physicians because it facilitates informed decisions by purchasers and it continues quality improvement efforts by providers.

Copic Insurance Company and Gadian Corporation (physician credentialing service) have agreed to

work with CMS to implement the Physician Profile Project. It is believed that the public, when given data by an independent company, will have much more faith in the information and in the subject doctor. Compiling Gadian profiles of physicians have already begun. Once all the information has been gathered and corrected a new profile, printed on Gadian letterhead will be available to patients through their physicians, and only their individual physicians' offices. In this way patients will be able to go to their physicians for information and know that the information provided has been checked by an outside agency. Moreover, it offers physicians and patients the opportunity to both discuss specifics about the data and make informed choices regarding provider care.

This data represents an important first step in the dialogue between physicians and the public about provider specific data. While it is not "outcomes data," it is a step in the right direction because valid, universal methods of collecting the outcomes data that so many are looking for have not been created. Accurate and acceptable physician specific outcomes data is the ultimate goal that CMS is striving for. The Physician Profile Project will benefit the patient by initiating that process by improving physician data.

On Doctors' Day 1996 remember the physicians that have cared for you, and doctors remember the patients you serve by participating in the CMS **Physician Profile Project**.

Important Notice To All CMS Members:

Public Access to Physician Data

RES-31: Improved Public Access to Data Concerning Physicians was referred back to the Health Affairs Council for rewording based on the advice of legal counsel at the 1995 Annual Meeting of the Colorado Medical Society (CMS). Legal counsel worked with the Data Committee and a revised resolution was passed by the Health Affairs Council in September. This resolution was then approved by the CMS Executive Committee and, subsequently, by the CMS Board of Directors in November. The action plan for this resolution is being developed for final implementation in April of 1996. This plan involves you, the physician community.

With that statement in mind, the following are some questions you may ask, and the answers supplied by Colorado Medical Society.

Q. Why this sudden interest in physician data?

A. The push for access to physician-specific data is continuing to grow. The physician community is perceived as being less than cooperative in this area. To help you respond in a positive and proactive manner, the **Physician Profile Project** was created in response to RES-31. This resolution states that CMS encourages the availability of useful, valid information on individual physicians that facilitates informed decisions by purchasers and continuous quality improvement efforts by providers.

Q. The big issue has been "outcomes data"; why isn't this included?

A. The resolution recognizes that while reliable and valid outcomes data for individual physicians are not yet available, there are some data which are already available and can be of use to patients. To that end, it states that CMS will work with the Board of Medical Examiners (BME), credentialing agencies and others to facilitate consumer access to the defined data and that CMS will publish and disseminate a patient brochure explaining how to access this information.

Q. What specific information is going to be included in this?

A. CMS is currently working with Copic Insurance Company and Gadrian Corporation (physician credentialing service) to implement this resolution. **By the time you read this, each physician should have received from Gadrian a profile which lists individual information for the following items:**

- a) medical school from which you graduated and date of graduation;
- b) graduate medical education;
- c) specialty board certification through ABMS (American Board of Medical Specialties) or AOA (American Osteopathic Association);
- d) number of years in practice;
- e) names of hospitals where you have privileges;
- f) location of your primary practice setting;
- g) identification of any translating services that may be available in your office;
- h) whether or not you participate in Medicaid and/or Medicare, and;
- i) final BME disciplinary actions.

Q. What is the physician expected to do?

A. You will be asked to confirm the accuracy of the data. If the data is accurate, you may copy the profile and make it available to your patients. Any changes should be returned to CMS. You will then receive a clean copy of the information, on Gadrian letterhead, which you can duplicate and make available to your patients beginning in April.

(Continued on following page)

Q. How were the data included in this profile chosen?

A. In determining what information should be included, CMS looked for data which was currently available to the public, (yet sometimes difficult for the public to access) which might be of use to patients in choosing their health care providers. We were very clear in our deliberations that malpractice claims were not useful information for anyone; however, final BME disciplinary actions, which are already public information, may be of more use.

Q. Is someone requiring that the physician participate in this project?

A. No! Participation in this project is completely voluntary and at no cost to you.

Q. What will be done to let the public know about this data?

A. The project will be developing a community education campaign. It will focus on informing the public about what data are useful and what are not, what data are currently available and how it can be accessed, and how to be a good patient and consumer of health care.

Q. How will the patient get this information?

A. We would like the patients to be able to access this information **through you, their physicians, and only through individual physicians' offices.**

Q. Will this information be considered reliable information coming from a physician's office?

A. Yes, however, the patients should be able to come to you for the information and know that the information provided has been checked by an outside agency. That is why you will receive your profile from Gadian on Gadian letterhead.

Q. Then what is the advantage of getting the information from me, the physician?

A. Getting the information from you allows your patients to discuss with you those elements that are important to them. This also tells your patients that you support their desire to make informed choices regarding their physician. You are then sure that your patient will receive complete, accurate information that you have reviewed and approved.

Q. The patient still has no "outcomes data", so what value will these data be to the patient?

A. While the data elements contained in these profiles may not be the "outcomes" data that many are looking for, they are available, useful and an important first step in a dialogue between physicians and the public about provider specific information. **Please participate.**

Be certain you've received your letter from Gadian and complete and return it as soon as possible. We hope to have the data in your hands and the community education campaign off and running by mid-April.

If you HAVEN'T RECEIVED the data questionnaire, call Colorado Medical Society and ask for someone handling the "Provider-specific data" program. **If you have further questions about the Physician Profile Project, call (303) 930-0413 or 1-800-654-5653, EXT. 2413.**

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ARCHIVES

by John L. Lightburn, MD, Historian
Colorado Medical Society

105 years representing some of the most difficult medical practice

Introduction:

An unexpected benefit of being the CMS Historian has been the opportunity to know the medical men and women who preceded us in Colorado. Limited by the primitive state of medical science, they practiced with incredible skill and art, persevering in spite of repeated frustrations and painful defeats. For the African-American physicians of that time, the social barriers and restrictions added even greater burdens to their clinical labors. One of those who practiced medicine in Denver for nearly half a century was Justina L. Ford, MD. Another was C. L. Hawkins, MD.

John L. Lightburn, MD



Justina L. Ford, MD

worked hard to become a physician, receiving her MD degree from the Hering Medical School in Chicago. Dr. Ford chose Denver as the location to start her practice in 1902 because of its pioneer spirit and because the state had just given women the right to vote. When she began her practice at 2335 Arapahoe, Dr. Ford was one of only five black physicians in Colorado and one of only a handful of female physicians.

Dr. Ford was denied membership in the Denver and Colorado Medical Societies, the American Medical Association as well as staff privileges in any hospital. Isolated from her medical colleagues, she applied several times for membership. In a letter seeking membership to the Denver Medical Society in 1949, she wrote that to many of her patients "socialized medicine might be particularly attractive ... I need recognition in the medical society for personal help and to help you preserve the present system". She added that "it has required patience and fortitude to endure as I have from 1902 to 1949".

Endure she did. During her long and distinguished career, Justina Ford delivered more than 7,000 babies. Lacking hospital privileges she established a successful and

notable practice of home deliveries. Of course there were critics of her home deliveries. However, she dismissed such criticism because her practice was largely to the poor and a majority of the deliveries could only be done at home. Dr. Ford was finally elected to the Denver and Colorado Medical Societies on January 12, 1950. Two years later, Justina L. Ford, MD, died at the age of 81. She had practiced medicine for 52 years.

In 1983, her home and office at 2335 Arapaho Street was restored and moved to 3091 California Street where it now houses the Black America West Museum and Heritage Center.

Dr. Clayton L. Hawkins, MD.

Twenty years ago, Dr. Cyrus Anderson, historian of the Denver Medical Society, recorded an interview with Dr. Clayton Hawkins about his 53 years of general practice in Denver. Dr. Bernard F. Gipson, Sr., aided in that interview. On December 9, 1995 Clayton L. Hawkins, MD, a retired General Practitioner, celebrated his 100th birthday. He is the oldest African-American physician in the state of Colorado. This birthday celebration was shared with his family, Afro-American health care professionals and friends. The following is a biographical sketch.

Dr. Hawkins was born in Melissa, Texas where he attended elementary and junior high school and worked on the family farm. He attended high school in McKinney, Texas, six miles from his home.

Justina L. Ford, MD

In 1898, when she applied for her Colorado medical license, the licensing examiner is said to have told Dr. Ford, "I feel dishonest taking a fee from you. You've got two strikes against you to begin with. First, you're a lady, and second, you're colored". Regarding those obstacles, in an interview many years later, Dr. Ford recalled that she had "fought like a tiger against the barriers of race and sex".

Born in Knoxville, Illinois, she knew early what she wanted and



Clayton L. Hawkins, MD
1995

After graduating from high school, Dr. Hawkins entered Bishop College where he obtained a Bachelor of Science degree. In college Dr. Hawkins played left-end on the varsity football team and was a pitcher on the baseball team.

The pursuit of his dream to become a physician began when Dr. Hawkins was admitted to the University of West Tennessee Medical School. Dr. Hawkins noted that the University of West Tennessee Medical School was special because it admitted African-Americans and foreign students, while the nearby University of Tennessee Medical School denied them admission. The same faculty taught at both schools.

After one year in medical school, World War I interrupted Dr. Hawkins' education when he was drafted into the Army. After serving 13 months he was discharged and returned to school to earn his MD.

On his way to Los Angeles in 1924, Dr. Hawkins stopped in Denver where he met a white physician named Curry. Dr. Curry convinced Dr. Hawkins to stay in Denver and take the Colorado medical license examination. Dr. Hawkins recalls that times were tough back then. He could not afford to take a \$25 class in the Empire Building to study for the state board. Dr. Curry paid the tuition for him, and the two went on to pass the state medical board.

During the 30 day waiting period after the board examination, Dr. Hawkins played the piano in a nightclub (probably a restaurant, since Prohibition had effectively closed most night clubs) for \$5.00 a night to survive. Fortunately, the music classes he took at Bishop

College saved him as he waited for his medical license.

In the early days of his practice Dr. Hawkins opened an office at 608 26th Street. It was during that time that African-American physicians in Denver had "Col." for colored behind their names in the telephone directory. House calls were common then, and Dr. Hawkins recalls the time when he was paid \$20 for a call during which he delivered a baby. For many years Dr. Hawkins could only get medical staff privileges at Denver General Hospital. He was admitted to the medical staff at St. Luke's hospital for the last 18 years of his practice.

In 1934 he moved his office from 26th Street to 2701 Welton Street. By that time his practice had increased. He was seeing 75-80 patients a day and was also a Selective Service Medical Examiner during World War II. After the war in 1946, Dr. Hawkins bought an apartment building at 434 26th Street and converted it into an office building where he practiced medicine until he retired in 1977 at the age of 81.

Dr. Hawkins was married to Mrs. Edythe Hawkins who passed away in 1995. Her father was the first African-American detective in Denver and he also served in the administration of Mayor Ben Stapleton. Mrs. Hawkins was the organist at Zion Baptist Church for many years. Dr. Hawkins' love of music continued as he joined his wife's efforts as one of the lead soloist in the church choir.

In spite of the many hardships he has experienced, Dr. Hawkins has enjoyed the profession of medicine. He states that practicing medicine has been "stimulating". Practicing with dignity and integrity, he finally became a member of the Denver and Colorado Medical Societies, as well as the American Medical Association and the National Medical Association. In his 53 years of continuous service, this pioneer African-American physician has contributed a great deal to the health care of the citizens of the city of Denver.

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Donation Benefits Denver Medical Library

A donation by the Rocky Mountain Academy of Occupational and Environmental Medicine, Inc. to the Denver Medical Library has provided the library with money to enhance its Occupational Medicine collection. The following new books have been ordered for the library's resources:

Klaassen. Casarett & Doull's Toxicology. 5th ed. McGraw-Hill, 1995.

Herrington. Occupational Injuries: Evaluation, Management and Prevention. Mosby, 1995.

Morgan. Occupational Lung Diseases. 3rd ed. Saunders, 1995.

Harper. Occupational and Environmental Respiratory Disease. Mosby, 1996.

Zenz. Occupational Medicine. 3rd ed. Mosby, 1994.

Rosenberg. Occupational and Environmental Neurology. Butterworth, 1996.

Contributions like this one benefit all the library's clientele by providing current materials that might otherwise not be possible to purchase.

Newborn Screening Program

The Newborn Screening Program Advisory Committee recommended that testing for maple syrup urine disease and homocystinuria be deleted from the list of conditions included in the newborn screening program. The committee also

advised that testing for these two conditions be discontinued. These proposed amendments to the Newborn Screening Regulations have been adopted. For more information please call Laura Taylor, Family and Health Services Division, Medical Affairs and Special Programs, at (303) 692-2425.

QuaLife Announces 1996 Support Groups and Classes

QuaLife Wellness Community has expanded its offering of support groups and classes in 1996 for persons coping with life-challenging illnesses. Groups are available for patients, survivors of serious illness, family members and friends of patients, grieving persons and healthcare professionals. All support groups are offered free of charge. The groups meet weekly or biweekly in Denver and Boulder.

New support groups include those for patients with ovarian and related cancers, myeloma and Hepatitis C. Ongoing support groups include those for men's cancer. For information, call Carole Lindroos or Myrna Bottone at (303) 393-9355.

New Publication

Contracting with Managed Care Organizations: A guide for the Health Care Provider, a new American Hospital Association book by Joseph A. Welfeld, FACHE, of Managed Care Resources, Inc., presents a strategic approach to managed care contracting. The book details a broad array of issues

including ways to prepare a provider for the shift to a managed care environment and negotiating the terms of managed care agreements. As a reference manual, *Contracting with Managed Care Organizations* guides executives on how to evaluate and negotiate agreements with managed care organizations and to determine strategic managed care relationships. As an adjunct tool, the book helps legal counsel to frame the key issues that might make or break a deal. As an educational resource, the book aids managers to orient employees to managed care concepts.

1996 Smoke-Free Dining Guide

Boulder, CO – The Group to Alleviate Smoking Pollution (GASP of Colorado) has released the 1996 Colorado Guide to Smoke-Free Dining. The 48-page guide lists more than 1,800 restaurants and eateries in 135 cities in Colorado that are 100% smoke-free.

For information on obtaining the guide call (303) 444-9799. Members of the Colorado Medical Society may obtain 20 or more copies at a special rate of \$0.30 each.

New Asthma Toll-Free Hotline

Physicians who treat asthmatics can now request a variety of support materials for patients and themselves through a toll-free program sponsored by Key Pharmaceuticals on behalf of UNI-DUR (theophylline) Extended-release Tablets.



Physicians who call the UNI-DUR Information Center at 1-800-X-UNI-DUR (986-4387) may request patient education and support material, clinical literature and to be called upon by a sales representative. The information center is operational 24 hours a day.

Surviving Capitation

When a physician is approached by an HMO style organization, he/she needs to ask a number of questions like: can I cover my costs at this price?; will I have enough money to pay my staff?; what is my level of risk? Depending on its payor mix, the success or failure of a practice can be dependent upon its evaluation of such contracts.

A recent publication entitled *Capitation: The Physician's Guide*, may help shed light on some of these confusing questions. Senior editor and Director of Medical Practice Financing and Systems at the American Medical Association, Mark Segal, Ph.D., explains that "the burden is placed on the physician to evaluate the rate, analyze the population to be served, accurately predict what utilization will be and calculate cost of services per member per month."

For more information about the publication, please call Mark Segal, Ph.D., at (312) 464-4726.

9Health Fair

Denver, CO. – For 17 years free health education and basic health screenings to citizens 18 years of age and over have been offered throughout Colorado and the Rocky Mountain region. The Colorado Medical Society is proud to once again endorse the 9Health Fair.

Free screenings at more than 120 sites consist of height, weight, blood pressure, vision and colorectal. Physicians, please advise your patients to attend the 9Health Fair, and have a copy of their blood reports sent to your office.

Other medical efforts at the 9Health Fair include: 1) evaluating of the efficacy of blood screenings; 2) exploring new ways to include more practitioners; 3) finding new ways to provide smaller and more portable equipment for easier transportation, particularly to rural areas; and 4) collaborating with agencies which provide mammography and childhood immunizations.

An optional thirty-three component blood chemistry analysis, including a coronary risk ratio, is available for only \$25. A 12-hour fast is required for accurate results. Men 40 years of age and over may take advantage of the prostate cancer screening through the blood chemistry for a nominal fee of \$15.

by Vicki Godbey
Executive Director

Additional free supplemental screenings of hearing, glaucoma, oral cancer, foot, body fat composition, breast exam, pap smear, mammography, body in balance, peripheral vascular disease, prostate/testicular, skin cancer and lung function examinations are offered at various sites throughout the state. Child immunization clinics will also be available at certain sites offered in partnership with the Colorado Rotary Clubs and the Colorado Immunization Coalition.

During the nine day fair, site information will be listed through 9NEWS and the *Denver Post*. Supplemental screening information in the Denver Metro area can be obtained by calling the 9Health Fair Hotline at (303) 778-7800.

Sponsors of the 9Health Fair include Provenant Health Partners, MetraHealth, a United HealthCare company, Lions Clubs of Colorado, the Colorado National Guard and 9News.

Volunteers are needed to assist this commendable project. Please call the Colorado Medical Society at 800-654-5653, Ext. 2418 or 9Health Fair at (303) 698-4455 for details on how you can help.



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FAMILY PRACTICE: Full-time opportunity for board certified family practice physician in busy family practice/urgent care clinic. Please mail C.V. to: Susan Clark, Plum Creek Medical, 410 S. Wilcox St., Castle Rock, CO 80104 or call 303-688-6900. 3/0396

FAMILY PRACTICE opportunities include: 1) solo practitioner looking for an associate, 2) faculty position for a 24-resident family practice residency program, 3) multi-specialty group, 4) two rural practices associated with multi-specialty group, 5) occupational medicine. **GENERAL SURGERY** group of four seeking to add additional surgeon. Burn and/or trauma experience preferred. **SPINE SURGERY** opportunity with group of six orthopedic surgeons. Fellowship trained preferred. Send CV's to: Sherry Kozero-Roth, Physician Support Services, North Colorado Medical Center, 1801 16th Street, Greeley, CO 80631. Phone 970-350-6644. 04/0196

SITUATION WANTED: Graduating pediatric resident with urgent care experience seeks position in a group practice or urgent care facility in Colorado. Residency ends June 30, 1996. Will be available soon after. Contact Anthony Nagorka, MD at (602) 269-2265 or 1901 E. Osborn, Apt. 151, Phoenix, AZ 85016. 01/0396

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

The Mysterious Mobius Loop



What in the world, you ask, am I doing writing about a loop? Well, because it's just another one of those things I uncovered in the corners of my mind, and it is something that has always intrigued me for its mystery and simplicity. I've studied it; I've actually used it; I've played with it and shown it, demonstrated it and done everything else with this loop I could think of.

When I ran across it the other day, rummaging through the cobwebs of cranial time, I was intrigued by one application I had never thought of before, and that is how much this device resembles the paths of our human lives.

So, what's the mystery? I thought you'd never ask. The mystery comes in the making of the loop and its not doing what you expected it to do when you created it. Isn't that life? If it doesn't apply to your life, it certainly does apply to a lot of us. Isn't that the way with kids? You create them, nurture them, try to train them, shelter and protect them, and what do they do? They do what they please, and it is seldom what you had envisioned when you created them.

This loop . . . called the "Mobius Loop", named for the man who first discovered it (*August Möbius, a German mathematician*). He called it "Mobius' Sheet" because what he did was take a rectangular sheet (the one I created in the picture is made from a sheet of paper 14 inches long by 1 inch wide) and he bent the rectangle the long way while twisting one end 180° and fastening the two ends together.

Here's how: First, take your sheet and lay it flat. Identify the corners of the rectangle with A, B, C, and D, thusly:



Now, attach the ends, using a piece of tape so that A meets D and B meets C. Bear with me. If you've never done this before, you will be surprised and amazed at what happens in the end (except that there won't be any end).

Remember, I said last month I was telling you this so that, as much

as anything, you could use it to entertain your grandchildren. All right, next step. When you have twisted the sheet and joined the ends, take a knife or a razor and cut a 1 inch slit down the center of the rectangle. Then take a pair of scissors, insert them in the slit and cut the sheet as if you were dividing the one loop into two loops. Whatever you have left of the loop, cut again the same way if you dare.

Back to the "**loop of life**". So many of us, if we examine our life experiences, discover we've performed in this same manner. We start out in one direction, having specific proportions to our physical and mental being. We are influenced by a variety of forces along the way, some acting as magnets attracting us or repelling us, thus twisting and shaping our lives. Then one day we look inwardly and find that, at least from a career perspective, we never finish. You ask, "Can that be?" Well, take the housewife's career as an example: She started in one mode, but her methodology has all along been influenced by familial developments. She thought she was going to live out a very normal career path, like that of the thoroughbred racehorse, whose career is one successful, winning loop after another. In his career, the racehorse at least gets back to the starting place. But the housewife's career resembles the Mobius Loop because it is forever changing. Every day she starts over, never finishing. NOTE: "quitting" is distinguished from "finishing". Like the Mobius Loop, maybe there is no finish until something wears out. And that's the end.



Joel M. Karlin, MD
President, 1995-1996

House of Delegates Presidential Address: March 23, 1996

It is a pleasure to be back with you today to report on our progress made in taking back control of our health care delivery system. As I have traveled our fair state talking with each of you at county medical society meetings, you have impressed me with the depth of your convictions...convictions that our health care delivery system must refocus on patients and the care that they need... convictions that the doctor-patient relationship must again become the focal point of the future of health care...convictions that physicians have been pushed around too long, pitted against each other, divided for the benefit of profiteers ... and now, after being beaten up so badly... you are ready to take back control.

And that is the key word... control. Who should have that control over how and when health care is provided? It reminds me of a story I heard last week in Washington. Senator Bill Bradley was attending a state dinner with the President. He had just taken his seat when the waiter began placing a single pat of butter on the bread plate of each guest. Senator Bradley asked the waiter for a second pat of butter, and the waiter replied that each guest could only get one pat of butter. At this, Senator Bradley became somewhat indignant, looked at the waiter, and asked, "Do you know who I am? I'm Senator Bill Bradley from New Jersey. I was an All American basketball player at Princeton, a Rhodes scholar, an NBA All Star for many years with the New York Knicks, a leader in charge of many important issues in the US

Senate; and someday, most likely a candidate for the Presidency of the United States." The waiter looked back and asked the Senator if he knew who he was. Senator Bradley, somewhat taken aback, shook his head in disbelief, and replied, "No I don't. Who are you?" At which the waiter replied, "I'm Bob, and I'm in charge of the butter". Well, it's time that patients and physicians once again take back control of health care.

... and I'm in charge of the butter!

This morning I would like to share with you a vision that I have had for the last several years, and what we at CMS have been doing to make that vision a reality. When matters on health care are to be discussed in this state, Colorado Medical Society should be at that table speaking for the welfare of our patients and our profession. We have gained the attention of the legislature, governor, Division of Insurance, community, health insurance industry, and the media, by actively participating in the dialogue, being reasonable, and advocating first for what is best for our patients. We have brought good ideas to solve problems, rather than criticisms to create controversy. We have negotiated where possible, but have taken a firm stand when negotiation would compromise our values. We have ventured into areas

where few have ever been willing to take the risk. Without risk, reward will not come. We came out publicly with our solution to the Medicare crisis, and when politicians divided on their directions, we supported the party which best represented our values. Yogi Berra once said, "When you come to a fork in the road, take it" ... and we did.

And when the issue of health care data came forth, we sat down with employers, who frequently call the shots on health care in this state, and told them that we had to be at the table. When small group reform went through the Colorado legislature in 1994, CMS was not part of the planning process. That is not acceptable. But what would we be willing to bring if we were to be part of the discussion?... The right way to look at physician specific data. I was told by several physicians early in my year as President-elect that I would amputate myself below the knees if I championed such a cause. But the environment is changing rapidly, and it is time that we as a profession validate what we do. Before a baby can run, that baby must learn to walk. And as a good beginning, with the help of the CMS Data Committee I brought to you last September at our Annual Meeting a proposal to take that first step. Tomorrow, at the State of the Society presentation, I will detail for you the elements of the Colorado Physician Profile Project, a collaborative effort between CMS, COPIC, and Gadian, which will be publicly released next

(Continued)

week, very appropriately on "Doctor's Day". When we take the next step, we will not repeat the early mistakes (made by some HMOs which inappropriately hurt too many physicians) by assembling and incorrectly interpreting incomplete global data.

Last September when I became your President, I told you that we would work to effect positive changes in the current system. And this would be our short term goal. HB 1216, the Prohibition of Gag Rules in physician contracts, was the first step taken in educating our legislators that problems do and will continue to exist in our current market driven system. Until we are granted the antitrust relief we need to exert collective muscle in negotiations with HMOs, we will, at times, need their help. As the Poster Child of HB 1216, I can tell you that our bill is on its way to becoming law.

Out of our White Paper deliberations, grew the Joint CMS/Colorado HMO Association Committee, where we have jointly begun to tackle other problems with managed care. We have just begun a new series of negotiations with the HMOs - this time on continuity of care. We must permit a patient, whose insurance is changed by their employer, to remain in an ongoing doctor-patient relationship for treatment of chronic illness. It is the right thing to do, and we will succeed in again creating the national model.

If we believe that the current system of profiteering in health care by large, for-profit HMOs is wrong, then it is our moral and ethical duty to move the system in a different direction. What would it mean to you and your patients if physicians determined what was appropriate care, when it should be delivered, and by whom? What would it mean if as much of the premium dollar as possible went to purchase health care rather than fill the pockets of HMO executives and investors?

What would it mean if you spent your entire day taking care of patients instead of arguing with non-physicians over the phone about the need to prescribe a certain drug, or perform a certain procedure, or refer the patient for specialty care? What would it mean if primary care and specialty physicians could determine amongst themselves how to create parallel incentives to provide the most appropriate care in the most cost effective setting for the benefit of...yes... the patient?

"Let's never easily accept the word 'no'."

Over the last two years, Colorado Medical Society worked hard to create the model for managed care which would help set the standards by which other companies would have to compete... Patient-focused, not investor-focused. Inclusive, not exclusive... Physician friendly, not physician intimidating... Last year through the confidence you showed in your medical society and the vision presented by your leadership, Colorado Physician Network became a reality. I applaud the Herculean efforts of Dr. David Martz, CPN President, and the CPN Board, in developing our own health plan. As Drs. Dave Martz, Jack Berry and I traveled around the state over the last 6 months, it became clear that once physicians understood what we were trying to do, the support grew. Today, CPN has over 2000 Colorado physician members, and our health plan will be operational by late spring. Tomorrow, you will hear more about the Rocky Mountain Physician Choice Health Plan from Dr. Martz. Let me say that after working with Mike Weber, Bruce Wilson, and their staff at Rocky Mountain HMO, we have chosen the right HMO partner. Physicians in rural Colorado have already begun to see the benefit of CPN. Another HMO,

attempting to enter that rural market, has already changed their physician contract and reimbursement provisions, attempting to be more competitive with CPN. Also, we could never understand why HMOs opposed the provision in our gag bill which prevented plans from restricting physician recommendations to patients over choice of health plan. The word soon came back that certain HMO execs believed that CPN physicians would try to coerce patients into dropping their plan and buying Rocky Mountain Physician Choice... hmm... By the way, that provision is still in the bill.

But in the end our mission must be to return control to our patients to be able to obtain that care which they feel they need. We as a society, must learn to come to grips with the fact that there is no one delivery system that works best for every patient. So many of the current problems can be corrected by putting the patient in control of the system. In such an ideal system, the patient would become a health care consumer. The patient, not their employer or government, would select the delivery system and plan, which best meet their personal and family needs. In such a system, quality, cost, and access would determine the winners. Although multiple funding sources would be used, in the end the patient would be in control. Sounds simple? Right. Common sense? Sure.

Well, where are we in effecting such change? In 1994, we took this concept to the AMA House of Delegates and it became AMA policy. Last June, we proposed a mechanism for implementation to that same AMA House of Delegates, and they approved it. Here it is... change the tax treatment of employer and employee contributions to health insurance so that when an employer offers health insurance at work, the employee can either opt to take that insurance or else to take that benefit in the form of a voucher to purchase individually selected and owned health insurance. That employee

could use that benefit to open a medical savings account... purchase insurance through their church, club or fraternal organization... join a voluntary purchasing alliance... or go into the open individual market. As a society, we plan for certain future events in our lives. We plan for our kids' education... We plan for our retirement... but we don't plan for nursing home care or end of life medical needs. Instead, we either heap those needs on to our children, or if they can't help, on to society as a whole. What if each new entrant into the work force opened a medical savings account and began funding these needs. They could do it for just a few dollars a week. Is this a revolutionary new concept? No, not really... It is the foundation of the Federal Employees Health Benefit Program which now allows over 80 health insurance options to Civil Service workers. During the last 15 years when the annual rate of rise of health insurance has exceeded 13%, this program has resulted in annual increases below 7% per year. No employer negotiating insurance rates... no wage and price controls... no global budgets... just getting the patient involved in an open, competitive market. And what happens to health plan accountability? Instead of it being directed to the employer solely on the basis of cost, it is now directed to the patient... and guess what?... on the basis of cost, quality, and access.

To move this concept forward I have met with Colorado legislators, and out of those meeting came a Joint Resolution written by Senator Mike Coffman and me, and submitted to the Colorado Legislature. Introduced two weeks ago, this resolution affirms the Colorado Legislature's support of the concept and urges the U.S. Congress and the President to pass enabling legislation. Representative Pat Sullivan is carrying it in the House. A copy of that Resolution is at your place.

The most gratifying event of my year as your President occurred a little more than a week ago while I was in Washington. Congressman

Dan Schaefer, a long- time friend, and supporter of our concept, facilitated a meeting with Congressman Mike Bilirakis, Chair of the Health Subcommittee on Commerce, where health bills originate. We met for 30 minutes in a small conference room while Committee hearings continued in the next room. The Congressman listened attentively while I presented our concept. He and Majority Leader Dick Armey were looking for a way to involve patients more directly. I applauded their efforts in writing legislation permitting medical savings accounts and provider networks, but cautioned that in our current delivery system where the employer selects the health plan, many employees would not be able to avail themselves of these changes. Our plan gave the same choice to commercially insured individuals that their Medicare plan gave to seniors. No longer would physicians have to ask Congress to fix managed care inequities. With our plan, accountability would occur directly from the health plan to the patient. If a patient or their physician disliked the policies of a certain managed care company, the patient could walk. The market, not Congress, would produce positive change. Congressman Bilirakis smiled, looked up at me and said, "I like it. Let's see how we can implement it." He asked me and AMA lobbyist, Margaret Weber, who accompanied me to the meeting, to prepare a concept paper for him over the next two weeks. The House is currently putting together their version of the Kennedy-Kassebaum Bill which is in the Senate. He believed that the potential existed to attach this concept to that bill, or else hold it over for the next Congress. I left that small conference room tingling from head to toe. Finally, we were on our way. This past weekend, my computer and I created our work product. By Sunday night, my portion of the concept paper was done. By Monday morning it was on the desks of Dr. Painter, Sandi Maloney, and select CMS staff for their comments. On Wednesday

night at 11:30 p.m., our collaborative version was complete, and on its way to the AMA to add the fiscal section, polish it up, and present it to the Congressman. Next Friday, I will be back in Washington at a meeting of my AMA Council on Legislation. Before that meeting, I will work with AMA to finalize our presentation. We have a great shot at really making a difference!

Two years ago, I lost my parents. They were my best friends. Although uneducated, Dad worked three jobs to keep a small roof over our heads, and taught me the value of hard work. Mom was the one who was around much of the time. She encouraged me each step of the way. At times though, she would say "no" ... you just can't do that. "Why?" I would ask. She would look at me, put her hand on my shoulder, and respond, "Why is it that you just can't take 'no' for an answer?"

I guess the reason was that my expectations in life had no bounds. Well, my expectations for you and our patients, for the Colorado Medical Society and the AMA, and for our joint ability to retake control of our health care delivery system, have no bounds. Let's never easily accept the word "no".

Call for Nominations

The Physician Award for Community Service, sponsored by Wyeth-Ayerst Laboratories, is designed to provide recognition to men and women who are actively engaged in the practice of medicine for the many and varied services above and beyond the call of duty which they render to their respective communities. The award was established in 1961 in appreciation for the time and personal sacrifice devoted by physicians to the welfare of their communities.

The Colorado Medical Society is now taking nominations for this award to be presented at the annual meeting in September. Nominees must meet the following criteria:

- 1) The nominee must be a licensed Colorado physician;
- 2) The nominee must be living; no posthumous awards are permitted;
- 3) The nominee must not have received this award previously;
- 4) The nominee must have compiled an outstanding record of community service.

Please help to promote the image of the medical profession in its ongoing efforts to be a positive participant in community life. Nominate a colleague today! Please call 779-5455 Ext. 2425 or 1-800-654-5643 for more details.

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

Liability Exposure Under the Health Care Availability Act

The Health Care Availability Act (HCAA) enacted by the Colorado Legislature in 1988 provides that the total amount recoverable in a malpractice case shall not exceed \$1,000,000, present value, and indicates that not more than \$250,000 shall be attributable to non-economic loss. Another statute indicates that there is no limit on the recovery of damages for physical impairment or disfigurement. It is debatable whether the \$250,000 non-economic damage ceiling included in the HCAA includes damages for physical impairment or disfigurement. There are exceptions to the \$1,000,000 ceiling in the HCAA. The court may determine that the value of lost past and future earnings or past and future medical costs may, when added to the value of other future damages, exceed the \$1,000,000.

Periodically, claimants seek an award of punitive (punishment) damages against a health care institution or professional. To prevail on such a claim,

a plaintiff must prove that actions of a health care professional or institution were attended by circumstances of fraud, malice, or willful and wanton conduct. It would appear that the \$1,000,000 ceiling would also be applicable to a claim of punitive damages. It is critical to remember that punitive damages are not covered by insurance. Most often, independent counsel is hired if there is a punitive damage claim. Often "independent" counsel will confer with the health care professional or institution's insurance carrier to encourage settlement within policy limits. Generally, the amount of punitive damages cannot exceed actual damages awarded to the injured party. However, if the plaintiff's damages are aggravated because the defendant has continued or repeated the wrongful behavior or acted in a willful and wanton manner during the pendency of the action, and if the defendant knew, or should have known, such action would produce aggravation, punitive damages may be extended.

If a damage claim has been asserted against a health care practitioner or institution, it is important to determine whether the damages fall within the category of (1) non-economic damages (with a statutory imposed cap), (2) disfigurement or impairment (which may well not have a statutory cap), or (3) economic damages (which do not have a cap). If punitive damages are ultimately alleged, or the possibility of such occurring exists, it would be wise to consult with independent counsel promptly to try and reach a prompt resolution of the claims within the insurance policy limits.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



There is an ancient Chinese curse that translates loosely into, "may you live in interesting times." Well, welcome to those times. As everybody knows, health care is really undergoing a sweeping transition due to several, economic, organizational and political pressures.

We tend to forget that health care delivery takes places in a business organization.

What we fail to realize, too, is the far reaching effects of the information management and tele-communication revolution. It's as if medicine is being dragged by its heels with its arms outstretched, fingernails in the pavement, kicking and screaming into the 21st century. Health care is the last major segment of the economy that is yet to be brought up under the telecommunications and information management revolution. As a non-profit organization, CMS underwent this revolution a few years ago. These changes are just now happening in medicine.

Current trends in health care show us that inpatient hospital census continues to fall and traditional fee-for-service medicine is decreasing. Managed care is the emerging paradigm. Capitation will shift the medical industry from a procedures-oriented industry to a services-oriented industry. What we are seeing is a huge consolidation of the medical industry; not an explo-

sion, but a huge **implosion** as major hospital systems acquire existing hospitals and physician practices.

The emergence of integrated delivery networks will continue and will fundamentally change the practice of medicine. The main force of this change is managed care.

Another concept is the "**integrated continuum of care**". Medical care is no longer only provided in clinics and hospitals. It is provided across a wide continuum of environments. From this point forward, competition will not necessarily be geographically based; it will be quality and cost based. Or, in other words, value based. What do you get versus what you pay for? Yes, medicine is really emerging as a true business.

What are the impacts of these forces of change?

- physicians will require decision support systems that limit cost while delivering quality care. These support systems, like it or not, will include protocols, critical paths, or practice parameters - whatever you wish to call them. Will this be the future of medicine? Regardless of how widespread the use of practice parameters becomes, it all cycles back to information management.
- health care delivery systems will be required to track costs and resource utilization.
- electronic linking of health care delivery organizations to medical data bases and records will be required.

Physicians are going to have to track outcomes to quantify what works and what doesn't. This is part of quality measurement and should be used to feed-back into the improvement of existing practice parameters. Outcomes will be measured more in the future than they are today. We often think of one type of outcome - clinical. Those in the business world feel that the other measurable outcome is a resource utilization outcome. The goal is to maximize the medical outcome and minimize the resource utilization outcome.

So what is the emerging role for telemedicine in health care? Most feel there is a need for increased use of telecommunications technology in the health care delivery arena. Running a business has certainly taught me that technology doesn't solve all the problems. In fact, many times technology creates problems. People solve problems. Technology is a tool to help a human solve a problem.

The simplest definition of telemedicine is the two-way transfer of medical data, medical information, and medical expertise between point A and point B. There are two very basic kinds of telemedicine technologies currently in use: the telephone and the FAX machine. Telemedicine has the potential of going far beyond this.

I stated earlier that managed care was the main force behind many of the changes we are seeing today in the health care delivery

(Continued on following page)

EXECUTIVE DIRECTOR'S UPDATE

(Continued)

system. Every physician member of CMS is, or soon will be, subject to Physician Practice Profiles (aka Report Cards) created by managed care organizations. Such information is created by a computerized data base. How many of you actually own and use a personal computer? Surveys show that one-third of the population of this country under 45 years of age have personal computers. Approximately 15 percent now actively use the Internet. I suspect that a survey of our Colorado physicians would show a much lower activity.

Telemedicine should be an integral component of your strategic plan. Be prepared to spend a higher percent of your practice revenue for an information system than what you spent in the past. Be prepared to demonstrate outcomes, to demonstrate patient accessibility, compliance and satisfaction. Be prepared to demonstrate your own cost effectiveness instead of positioning your own opinion about how acceptable your performance is. Lacking data, your opinion does not carry much weight in the future of managed care. Managed care plans have data **today**. Whether it is valid and reliable is a different issue. Whether they are measuring artificial

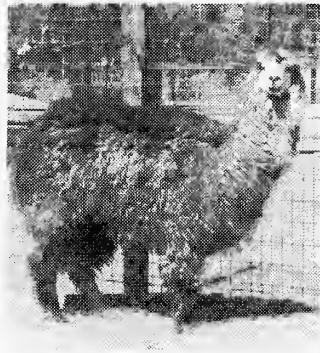
indicators of quality is not a reality because the reality is, **their suspect data beats your lack of data**.

The new medical paradigm involves the use of telemedicine, including the collection of data. We are long past simply having people on the phone or using the FAX. Preparing for managed care plan report cards, internal quality improvement data, the conveyance of medical images (perhaps across state lines), and on-line accessibility to a multiple team of physicians looking at the same data coincidentally is just the beginning.

"May you live in interesting times."

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(719) 275-2701

Leadership and evolution

by M. Ray Painter, MD
President-Elect
Colorado Medical Society



The last month has been like a trip to the Galapagos Islands. Charles Darwin I am not. But the amount of feedback that I have received regarding the upcoming CMS reevaluation project has made me wonder how the British naturalist felt when he proposed the theory of evolution.

In February I sent a letter to all of the component society leaders and the CMS Board of Directors asking for their thoughts on how CMS can better support physician members and patients. The plan was to appoint task forces to explore and review evolutionary issues. Those task forces and others would then join me at the Leadership Conference in Breckenridge on May 18-19. I am pleased to report that a majority of the component societies have participated in the first round of the project. Round two has now begun. Not all of the information has been collated yet, but I will share some of the highlights with you now.

In last month's edition of *Colorado Medicine*, I posed a number of questions. I asked if CMS should be separated into two distinct entities or functional segments to address physician and patient needs respectively. **There was a general consensus not to split CMS into two separate organizations.** Strong support for resolving conflicts in the profession and more effective physician advocacy continued. One proposal suggested a for-profit subsidiary.

Another proposal questioned if a permanent physician C.E.O. or Executive Vice President of CMS should be instituted. Reaction to this

proposition was mixed.

One interesting proposal presented by a task force addressed the issue of alternative medicine. Specifically, interest was expressed in expanding the scope of medical practice to include alternative modes of delivery such as acupuncture and chiropractic.

As round two of the reevaluation project begins, here are some questions from round one to consider:

- How can we better define patient and physician advocacy functions? What services and products should we provide to support these functions?
- If a full-time physician is hired as C.E.O. or Executive Vice President of CMS, how do we define his/her role and redefine the role of the president? Instead of an executive vice president, are there other roles that a full-time or part-time physician should be hired to fill, like lobbying?
- Should CMS embrace the concept of alternative medicine with the goal of controlling and improving the quality of alternative practices?

I encourage you to read last month's article. Discuss these issues with your colleagues. Your input is valuable and it can make a difference. Similar to the commotion that followed the introduction of Darwinism, discussions have begun and new ideas are being formulated on how to make CMS even better and stronger. **Join me at the Leadership Conference in Breckenridge on May 18-19**, and think about how this organization must evolve to respond to present and future needs.

"Similar to the commotion that followed ... Darwinism, discussions have begun ... on how to make CMS even better and stronger."



LETTERS TO THE EDITOR

Editor:

Recently I read an article about Hubert Work, M.D. (*Colorado Medicine Magazine*, Vol. 93, No. 1, Jan. 1996).

The article does not mention Dr. Work's early years in the practice of medicine in Fort Morgan, Colorado. Because of the many past and present people named "Work" in this community, I was able to obtain a genealogy of the Work family. It is titled "Work Family History Twelve Generations of Works in America 1690 - 1969".

On page 140, paragraph 336, it states that Dr. Work graduated from the University of Pennsylvania Medical School in 1885. He planned to go to California following graduation to begin practicing medicine. He stopped in Greeley, Colorado to

visit a cousin and while there developed Typhoid Fever. He was nursed by his cousin's wife and while recovering he met the sister of his cousin's wife. They were married and moved to Fort Morgan, Colorado where he practiced medicine.

Dr. Hubert Work is mentioned several times in a publication of the Fort Morgan Museum titled "*One Hundred Eleven Trees*" - a compilation of Biographies by the Memorial Tree Planting Committee of the Fort Morgan Heritage Foundation, Inc.

- On page 22, mention is made of the young Dr. Work treating M. L. More for Typhoid Fever. This was the latter part of 1889.
- Page 46 mentions that Dr. Work suggested to Dr. F. W. Lockwood that he should come to Fort Morgan to practice medicine.

--- Page 137 describes two women who were Dr. Work's nurses until he left Ft. Morgan in 1892 to establish Woodcroft Sanitarium in Pueblo, CO.

- Page 149 gives an account of his delivering a baby boy in 1889.
- Page 193 describes his care of three children ill with diphtheria, the eldest son died January 1, 1891.

I have added these references so their authenticity may be checked. I would appreciate your adding this additional history of Dr. Hubert Work and publishing it in the *Colorado Medicine* magazine.

Sincerely,
R. B. Richards, M.D.

April 4th: Denver Medical Society turns 125

The year was 1871. Denver was a town of great speculation and optimism. People were still following the advice of Horace Greeley and going west. The American Medical Association was already 22 years old, but Denver, with its rapidly growing population, could no longer be served by one organization for all. It became apparent to Drs. Arnold Stedman and Richard Buckingham that demands on individual physicians were becoming too great and

the need for an organized structure was upon them. Along with Drs. W. F. McLellan, F. J. Bancroft, A. L. Justice, E. C. Gehrung, David Heimburer, John Elsner and Bibb, the first meeting was held and the process to formulate was under way.

The *Rocky Mountain News* published the following account, with the resolution for organizing a medical association of ". . . all persons who consider themselves to be regular practitioners of medicine, and who

do not practice medicine upon an exclusive dogma, are invited to take part in the organization of said society; and that any objections being made to such person or persons taking part in said meeting must be sustained by a majority of those present."

And thus, the Denver Medical Society was born, being the forerunner of the Colorado Medical Society, which was organized just five months later in that same year.



by Richard Allen, MD, Chairman
Council on Legislation

Fast and furoius activity continues at the State Capitol as the midpoint of the legislative session approaches. Activity on the federal level is also continuing. Some may think that health care has taken a back seat to budget battles and presidential politics. This month it is appropriate to review issues on both levels to see where things stand.

On the federal front three issues are of concern: 1) antitrust relief for physicians; 2) Medicaid/Medicare reform; and 3) maldistribution of the physician workforce.

The AMA has been working hard to ease antitrust restrictions on physicians. Thanks to a barrage of grassroots and community support, organized medicine scored its first victory on this issue when the House Judiciary Committee voted 20-4 in favor of HR 2925 last month. Despite heavy opposition by the insurance industry, Rep. Henry Hyde's bill has moved on for consideration by the full House of Representatives. No date has been scheduled for floor consideration, but the bill has strong bipartisan support.

Bipartisan support for Medicaid reform may be waning. A recent proposal drafted by the National Governors' Association breathed new life into the debate, but it too has come under fire as the impasse on the federal budget persists. The ongoing theme has been to give states more power to run the program through such things as block grants. But hashing out the details of curbing federal spending continues.

Medicare reform has also been tabled as a result of bipartisan

bickering. Medicare reform may resume due to recent reports that there is an oversupply of physicians in the United States. "U.S. Physician Manpower Needs" (*Archives of Internal Medicine*, Vol. 156, January 8, 1996, pp. 21-24) concludes that there are too many specialists and not enough generalists. The study also notes that while there is no shortage of American physicians, a huge influx of international medical graduate students has created a surplus. As the managed care crunch continues, this increased competition in the shrinking job market may bring more bad news to many physicians. Reforms in the Medicare program may address this issue because those international graduates are being trained with Medicare dollars provided by U.S. taxpayers

The PEW Foundation recently released a study on the dire straits of the Medicare program, specifically on funding for residency training programs in medical schools and hospitals. These grim statistics about the impending bankruptcy of the Medicare trust fund reaffirm the fact that reforms must be made. Medicare reform and physician manpower maldistribution will profoundly impact the profession.

On the state level, budgetary concerns have killed a bill which would have helped provide health care for uninsured Coloradans. **HB 1191**, drafted by the Governor's Task Force on Caring for the Uninsured and sponsored by Rep. Ben Clarke, MD, was narrowly killed in the Finance Committee. It would have issued tax credits to private and public joint ventures that maintained

"...shortsighted concerns derailed health care plans that would have saved money and lives in the long run."

health care for the needy. These partnerships would have provided preventive care like child immunizations, prenatal care and hypertension screening to the more than 500,000 uninsured Coloradans. It would have also reduced the amount of expensive episodic care that uninsureds generate through the overuse of emergency rooms. Once again, shortsighted concerns derailed health care plans that would have saved money and lives in the long run.

Many other bills of interest are in a holding pattern.

Bills awaiting action in Appropriations Committee include:

- SB 41 - Subfund for the Division of Registrations;
- SB 92 - Expansion of the Scope of Practice for Optometrists;
- HB 1073 - the CMS-sponsored Rural Health Bill; and
- HB 1125 - Concerning the Executive Director of the Department of Health.

Several bills are awaiting final approval.

- SB 107 - Workers' Compensation IMEs;
- SB 112 - Data Collection;
- HB 1216, the "Gag" bill;
- HB 1232 - Mandatory Health Benefit Plans; and
- HB 1264 - Purchasing Alliances.

P

physician profile project

Questions and answers

by Ellen Stein
Director CMS

Division of Health Care Policy

The response to the Physician Profile Project has been phenomenal. However, many physicians still have questions about the program. The following attempts to answer some of the most commonly asked questions.

What is the Physician Profile Project?

The Physician Profile Project was created in response to a CMS resolution which **encourages the availability of useful, valid physician information which would facilitate informed decisions by purchasers and continuous quality improvement efforts by providers**. The project is a joint venture by CMS, Copic Insurance Company and the Gadian Corporation. Participation in this program is strictly **voluntary**.

Currently there is no credible way to produce meaningful physician specific outcomes data. However, some data is available that may be useful to the general public and health care consumers. **Rather than doing nothing while we wait for good outcomes data, we can do a better job of making existing information more accessible to the public**. The Physician Profile Project was created for this purpose.

The Profiles are an important first step in a dialogue between physicians and the public about physician specific information.

This project is NOT -

The Physician Profile Project is **not** a CMS credentialing project. While CMS is working with health plans and hospitals to standardize the credentialing application, the Physician Profile Project has nothing

to do with those efforts. The Physician Profile Project is strictly a tool for physicians to use in communicating with patients and the public.

How will these profiles be disseminated?

Your profile will **only be available through your office**. Neither CMS, Gadian nor Copic will disseminate profiles. We will only be distributing brochures about the project. The brochures will **not** contain physician names.

Who received Physician Profiles?

Over 3,700 CMS members received their individual profiles. This group consisted of physicians who were already in the Gadian data system (i.e. physicians who are associated with health plans or hospitals who use Gadian for credentialing verification).

If I did not receive a profile, can I still participate in the project?

Yes! CMS encourages participation in this program. For information on how to begin the process, please call Ellen Stein at 930-0414 or 1-800-654-5653.

Why was there incorrect information on my profile?

Your profile contains specific data elements that were chosen for this project. It was generated using data from the Gadian data base which is being updated continuously. It may be that at the time these profiles were printed, information which was previously obtained from you had not gone through the verification process yet. Addition-

ally, if you have an application with Gadian which is in the process of being completed, verified or updated, those changes may not have been reflected on your recent profile. Other problems could have caused the inaccuracies. However, that is why the profile was sent to you initially, so that mistakes are detected and the correct information is placed on your final profile.

If I corrected my profile, will I get a new copy?

Yes, send it to Ellen Stein at CMS. Corrections that you made will be verified with the primary source (e.g. your medical school). Your profile will then be updated and returned to you in approximately 3-6 weeks. From that point on it is yours to keep. **We encourage you to copy it, attach any addenda you choose, and make it available to your patients.**

Correction

A letter sent to members detailing the Physician Profile Project listed the incorrect phone number for the hotline to call for more information. The correct hotline number is (303) 930-0413. For more information on the Physician Profile Project please call the hotline number or Ellen Stein at CMS.

CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Dr. Terry Sullivan Elected President of State Board of Health

Dr. Terry Sullivan, former secretary-treasurer of the Colorado Medical Society, as well as former president and treasurer of the Denver Medical Society, has been elected president of the nine-member Colorado State Board of Health. Dr. Sullivan is currently the president of the Colorado Association of Managed Care Medical Directors, and board cochairman of the Rocky Mountain Transplant Bank. He was the corporate medical director for Clinicare in Denver, and now serves as the managed care medical director for the Rocky Mountain Health Care Corporation, an affiliate of Blue Cross and Blue Shield of Colorado.

Suzanne Becquet, a Lamar businesswoman, is the board's new vice president. A former secretary of the

Colorado Rural Council and assistant to the Colorado lieutenant governor on rural council activities, Becquet is an entrepreneur from Lamar, Colorado. She is the current finance chair for the High Plains Health Clinic. Becquet has chaired the Colorado Healthy Communities Initiative for Prowers County, and was chairman of a committee which restructured social services for a six-county area of southeastern Colorado. She is also the former president of Health Resources Inc.

The Colorado State Board of Health advises the Colorado Department of Public Health and Environment. The Board also reviews public and environmental health activities and adopts rules and regulations governing those activities in Colorado.

Legal Defense Fund for Physicians Established

FARFEP (First Amendment Rights Fund for Every Physician) was established in 1994 to help *any* physician who is sued for writing or speaking up on any medical issue. FARFEP is a 501 (c)3, tax-deductible First Amendment fund created to allow an individual physician to speak the truth about the "business" of medicine without fear of being crushed by the expenses of a meritless lawsuit, as well as to educate the public. The fund is ready and willing to assist in the defense of *any* physician to protect his or her First Amendment Rights. Contributions and inquiries can be sent to FARFEP, PO Box 1968, Santa Fe, NM 87504.

Newborn Screening Tests Halted

Effective April 1, 1996, testing conducted on infants born in Colorado for Homocystinuria (HCU) and Maple Syrup Urine Disease (MSUD) will be discontinued. The Colorado Board of Health has determined that HCU and MSUD screening no longer meet the criteria set forth in the Newborn Screening Act.

It has been determined that the incident rate for these diseases is too low to warrant screening. Although screening is not performed for HCU and MSUD, consultation and confirmatory testing for symptomatic infants is available through the Inherited Metabolic Disease Clinic at The Children's Hospital. Contact the Newborn Screening Unit of the CDPHE Lab at (303) 691-4715 for more information.

Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Does the statutory cap on damages for medical malpractice claims really cap damages?

Yes and no. For the most part, plaintiffs can recover no more than \$1 million for injuries or losses arising from a course of health care, regardless of the number of defendants providing that care. Of that \$1 million, no more than \$250,000 may be attributed to non-economic loss or injury. Non-economic loss or injury is defined as pain and suffering, inconvenience, emotional stress and impairment of the quality of life. Juries are not informed of any limits set by statute, and are free to award economic and non-economic damages in any amount proven by the plaintiff.

The practical effect of the statute is to require the reduction of damage awards exceeding the limits. Thus, for example, if a plaintiff is awarded \$1.5 million for past and future pain and suffering associated with unsuccessful back surgery, the award will be reduced to \$250,000. Similarly, if the jury finds that a plaintiff will incur future economic losses (other than lost earnings) totaling \$2 million, the court will reduce the award to bring it within the statutory cap.

However, the statute allows damage awards to exceed the statutory cap when the plaintiff proves that the loss of future income or the expected future medical and other health care costs will exceed the \$1 million cap. The statute sets no limits on the amount by which an award for future lost earnings and for future medical and health care costs may exceed the statutory cap.

As a result, in catastrophic injury cases and cases involving the injury or death of a breadwinner with significant income and work-life expectancy, the statutory cap provides little, if any, protection beyond the cap for non-economic loss or injury which still applies. So, for example, when a 35 year old attorney with a successful law practice is reduced to the intellectual status of a 4 year old by a surgical misadventure, the patient may recover the total present value of his or her future lost wages, even if that amount exceeds \$1

million. Similarly, if the patient will require future health care, including attendant care, as a result of his or her injury, that too is recoverable in amounts exceeding the cap.

The cap on damages is part of the Colorado Health Care Availability Act, a comprehensive statutory scheme designed in part to regulate the amount recoverable in malpractice cases, as well as the timing of payments for future losses. In addition to setting the cap on damages, the Act requires the jury both to determine the amount of any future loss of earnings and future health care costs, and to specify the period over which those damages will be incurred. When the award of future damages exceeds the present value of \$150,000, the trial judge will order those damages paid by periodic payments, as those future damages accrue. Competent adults who have obtained financial counseling, and who can demonstrate that they are making informed decisions, can ask the Court to award a lump sum as opposed to future periodic payments.

The Act recognizes the use of annuity contracts to fund future periodic payments, as well as the practice of assigning those contracts.

Punitive damages

The Act also regulates punitive damages in several significant ways. First, plaintiffs can no longer ask for punitive damages in their complaints. This restriction follows prior legislative action prohibiting plaintiffs from demanding monetary amounts – typically many millions of dollars – in their complaints. Before a plaintiff can even ask for punitive damages, he/she must establish through discovery that the doctor's actions were attended by circumstances of fraud, malice or willful and wanton conduct.

Second, punitive damages may not be awarded as a result of the use of any drug or product approved for use by any state or federal regulatory agency and used within the approved standards for those drugs and products, or used in accordance with standards of prudent health care professionals. Additionally, punitive damages may not be imposed if the clinically justified use of the drug or product is beyond the regulatory approvals or standards, and is in accordance with standards of prudent health care professionals, and when the use has been agreed to pursuant to the written informed consent of the recipient.

Finally, as a general rule punitive damages in medical malpractice cases cannot exceed the amount of actual damages. The court may reduce or disallow the award of exemplary damages under certain circumstances: the deterrent effect of the damages has been accomplished; the conduct has ceased; or, the punitive purpose of the award has been otherwise served. Conversely, the court may increase the award to three

Malpractice (continued)

times the amount of actual damages if the defendant continues or repeats the behavior in a willful and wanton manner while the case is pending, or if the defendant's willful and wanton conduct while the case is pending has aggravated the damages.

In summary, the cap on damages has holes in it. In cases involving patients with catastrophic injuries, the cap does not prohibit the full recovery of economic

damages for future lost wages and future medical and health care expenses. Both before and after enactment of the Act, those elements of damages typically drove up the damage awards.

The Act is more effective and more certain with respect to recovery of non-economic damages, which are capped at \$250,000, regardless of the number of plaintiffs, the number of defendants, or the catastrophic nature of the injury.

More Support for Mammography Screening for Women Age 40-49

The recent results of a review of major clinical trials in Sweden strongly support mammography screening for women in their 40s, according to the American College of Radiology, the American Cancer Society and the Y-ME National Breast Cancer Organization.

Their review showed a 24 percent decrease in deaths from breast cancer among those women invited to have screening compared to those women who were not invited. The results found that a 35 percent decrease in deaths could result if mammographic screening was done every two years for women in the 40-49 age group.

Medical Ethics Essay Contest

The El Paso County Medical Society and El Paso County Foundation have organized a Medical Ethics Essay Contest for 11th and 12th grade students in El Paso and Teller Counties. Participants must write on one of four scenarios concerning medical ethics. Judges will be looking for insightful, creative, original thought in analyzing these complex medical-ethical issues and presenting ethical approaches for society in managing these questions in the future. The first prize for students is \$1,000. The school first prize is \$600. Contact the El Paso County Medical Society at (719) 591-5649 for more information.

Rocky Mountain Village Easter Seal Camp

Volunteer physicians help make summer camp safe and special for children and adults with disabilities. Physicians are needed to help the on-site nursing staff provide professional medical care for campers and staff during their residential summer camping season. **REWARDS ARE MANY!**

In addition to working with a dedicated and motivated staff, actually practicing medicine on occasion, lodging and meals for physicians and their families are provided.

The Colorado Easter Seals Society has operated the Rocky Mountain Village summer camp at Empire Junction in the Clear Creek Valley since 1951. While the camp offers exciting traditional camp activities like fishing, arts and crafts and horseback riding, its location serves as an excellent base for touring local attractions such as Summit County, Rocky Mountain National Park and Georgetown. Volunteer today.

**Call Paula Breeden, RN, Health Care Services Dir.
(303) 892-6063**

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Medical Records Institute

Toward an Electronic Patient Record '96 Conference
May 11-18, 1996
San Diego, California
Contact: Kimberly Allen (617) 964-3923

MGMA/CRAHCA

7th Annual Conference of Administrators in Oncology/
Hematology Assembly
May 15-17, 1996
Denver, Colorado
(303) 397-7876

Colorado Medical Society

Leadership Conference
May 18-19, 1996
Beaver Run Resort, Breckenridge, Colorado
Contact: Sandy Finney (303) 779-5455 Ext. 2406

MGMA/CRAHCA

7th Annual Conference of Administrators in Oncology/
Hematology Assembly
May 15-17, 1996
Denver, Colorado
(303) 397-7876

International Meniere's Disease Research Institute

9th Annual Electrococleography/Otoacoustic
Emissions/Intraoperative Monitoring Seminar
Summer 1996, Denver, Colorado
AMA and ASHA CEU's offered
Contact: Jane Wells or I. Kaufman Arenberg, MD
(303)778-4235

Society for Computer Applications in Radiology

Symposium in Computer Assisted Radiology
June 6-9, 1996
Denver, Colorado
(703) 716-7548

American Medical Association

Organized Medical Staff Section(AMA-OMSS)
27th Annual Meeting
June 20-24, 1996
Chicago, Illinois
(800) 262-3211

Colorado Society of Osteopathic Medicine

Annual Meeting
June 21-23, 1996
Manor Vail Lodge, Vail, Colorado
18 hours AOA category 1-A CME credits, FP and
Physician Assistants credits
Contact: Patricia Ellis (303) 332-1752

Colorado Otolaryngology and Maxillofacial Society

The Cutting Edge of Otology
July 24-25, 1996
Doubletree Antlers Hotel
Colorado Springs, Colorado
Contact: Bob Conlon, MD or Debbie Brown
(970) 484-8686

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-
on Training and Report Analysis Workshop
June 27-28, 1996
Englewood, Colorado
(303) 397-7876

American Psychiatric Association

Dynamic Psychotherapy in the New Era
July 29-August 2, 1996
Aspen, Colorado

18 Hours CME Credit, Category 1
Contact: Maria Gorrick (202) 682-6145

American College of Cardiology

Echocardiographic Symposium on 2-D and Doppler
Echocardiography
July 29-August 1, 1996
Vail, Colorado
23 Category 1 AMA
(800) 253-4636

President-elect's Leadership Conference **CMS Reevaluation Project**

May 18-19, 1996, Beaver Run Resort, Breckenridge, Colorado

REGISTRATION FORM

- I plan to attend the Leadership Conference to be held May 18-19 at Beaver Run Resort in Breckenridge.
- My spouse will attend both the Conference and dinner on Saturday night.
- My spouse will attend the dinner on Saturday night.

Name

Component Society

Name of Spouse

Mail your completed registration form to:
CMS, PO Box 17550, Denver, CO 80217-0550
Fax: 303-771-8657 or Phone: 303-779-5455 or 800-654-5653

Beaver Run Resort Registration Form

Group Name: Colorado Medical Society

Name _____

Address

City

State Zip

Home Phone

Work Phone

Please list all roommates in unit

Arrival Date

Departure Date

Accommodations: Please indicate your first (1) and second (2) choices below: (Please use this form for one room only.)
TYPE: _____ Applicable Rate: _____ Basic _____ Max _____

<input type="checkbox"/> Deluxe Studio with Spa	95.00	2	4
<input type="checkbox"/> Colorado Suite with Spa	100.00	2	4

Note: Maximum occupancy cannot be exceeded. The above rates do not include state or local taxes. Check-in time is 4:00 PM. Check-out is at 11:00 AM. Sorry, pets are not permitted in rooms.

Please state building preference to the reservationist (CMS recommends Building 4).

Deposit and cancellation policy: A deposit of one night per unit is required within 16 days to confirm the reservation. Deposit will be refunded less \$75.00 handling charge per room if cancellation is received prior to 72 hours before arrival. Full payment is due upon departure. Reservations received after May 3 will be on a space-available basis.

Enclosed is a check or money order for \$ _____

I authorize the deposit amount of \$ _____ to be charged to my credit card:

Visa Mastercard American Express Credit Card # _____ Exp. _____

Print name as it appears on the card: _____ Signature: _____

Please mail this form to:

Beaver Run Resort, P.O. Box 2115, Breckenridge, CO 80424 or call 1-800-525-2253

Colorado Medical Society
Leadership Conference

May 18-19, 1996
Beaver Run Resort – Breckenridge, CO

TENTATIVE Schedule

Friday, May 17, 1996

12:30 p.m.-	2:00 p.m.	Finance Committee
2:00 p.m.-	5:00 p.m.	Board of Directors
7:00 p.m.-	9:00 p.m.	Working dinner for facilitators

Saturday, May 18, 1996

8:00 a.m.-	8:30 a.m.	Continental breakfast
8:30 a.m.-	8:40 a.m.	Welcome—M. Ray Painter, MD
8:40 a.m.-	9:40 a.m.	Conference overview - Dr. Painter and Facilitator
9:40 a.m.-	10:00 a.m.	Break
10:00 a.m.-	12:00 noon	Breakouts - physician facilitators
12:15 p.m.-	1:15 p.m.	Working lunch - update on breakouts
1:30 p.m.-	3:30 p.m.	Breakouts - physician facilitators
3:45 p.m.-	5:00 p.m.	Nominating Committee
6:30 p.m.-	7:00 p.m.	Cash bar
7:00 p.m.-	9:00 p.m.	Dinner

Sunday, May 19, 1996

8:00 a.m.-	8:45 a.m.	Breakfast
8:45 a.m.-	10:30 a.m.	Reports from breakouts and wrap-up

“Your Doctor Will See You Now, Ms. Smith.”

How important is the relationship between patients and their physicians?

COMPAC, the political arm of the Colorado Medical Society, is working day in and day out to strengthen that physician-patient relationship..

COMPAC works for you, the physician, and your patient every day by giving support to those legislative candidates who have illustrated strong support for patient choice.

COMPAC is sending our legislators the message that physicians will stand up for their rights. During this session, the Colorado Medical Society has helped draft a bill which would remove restrictions from managed care contracts which presently prevent physicians from discussing patient coverage under the plan, or recommending treatment outside the plan. Call your legislator and ask him or her to vote for HB 1216, today. (House of Representatives 866-2904, Senate 866-2316)

But **COMPAC** needs your financial help, too. Without your support, **COMPAC**’s job becomes much more difficult, if not impossible. Join the hundreds of other Colorado physicians fighting for the rights of their patients — join **COMPAC** today!

HELP COMPAC HELP PHYSICIANS AND PATIENTS

Annual Membership Dues:

\$150 1996 Election Fund
 \$15 Resident Member

\$100 Sustaining Member
 \$5 Student Member

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Office Phone: _____

Make your personal check payable to: COMPAC, P.O. Box 17550, Denver, CO 80217-0550
Contributions are not limited to the suggested amount. Neither COMPAC nor its AMA affiliate, AMPAC, will favor or disadvantage anyone based upon the amounts of, or the failure to make PAC contributions.

CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Epilogue on Copic's Annual Meeting -- How We're Meeting Your Needs

Copic held its Annual Meeting February 22-23 with our Board of Directors (12 of 15 are practicing physicians), Copic's departmental vice presidents, and our actuarial, investment, accounting and legal consultants. Copic ended 1995 with 170 additional insureds (for a total of 4,368 physicians). We added six new medical entities (for a total of 21) and now insure nine hospitals. We will again receive a clean, unqualified financial audit, and are pleased to report that our investment income was more than adequate to cover operating expenses. Copic reserves were certified as appropriate, and a \$6 million policyholder distribution is planned for 1996. (The distribution reflects our continued commitment to return favorable loss developments to our policyholders.)

Foremost among the many topics discussed at the meeting was our insureds' continually expanding and changing needs. For example:

- Because our insureds need it, we now have the capability

through our reinsurer to provide excess coverage for our medical entities (from \$1 million to \$10 million) and hospitals (up to \$40 million).

- As an increasing number of our insureds participate in capitated plans that require them to assume significant financial risk, the need has arisen for protection against losses that exceed the capitation agreement. To meet this need, Copic has entered into a relationship with a national insurance holding company, with assets greater than \$16 billion, which can immediately provide us with expert capitation stop loss insurance. (You'll hear more about this product in upcoming Copic publications.)
- We also have an increasing number of physicians whose practices cross state borders. Copic is in the preliminary stages of considering regional expansion to meet this need.
- The Advanced Practice Nursing Bill may increase exposure for our physicians. Copic is working with the Colorado Nursing Association to design appropriate collabora-

tive agreements to control the risk and decrease the exposure in this arena.

- Horizontal and vertical integration have shifted the purchasing of professional liability insurance from the individual physician's office to a corporate purchaser. We recognize that under this scenario, we will need to work more closely than ever with brokers and are designing appropriate solutions.
- Copic is also positioning to respond creatively and effectively to our insureds' credentialing and NCQA (National Committee for Quality Assurance) office assessment needs (more on these in future Copic publications).

Pessimists complain about the winds of change; optimists hope they will go away. Realists adjust the sails, converting the threat of these winds into opportunities. Copic is committed to realism as our insureds' new needs are "blown in" by the changing winds of the health care industry.

Remember:

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues. 1996 is another critical legislative year to medicine.
Help.... however you can!



Women in Medicine Section Leadership Conference 1996



"Women Empowering Women"

The Women in Medicine Section (WIM) of the Colorado Medical Society provides a means for women physicians to network and participate in organized medicine. In 1995 WIM organized a conference to address issues of importance to women physicians. With over 130 attendees, the conference was a huge success. This year's conference, to be held at the Embassy Suites Hotel in Englewood on April 20, 1996, will be even better. Free on-site child care will be provided by the Thomas Learning Center.

The keynote speaker will be Dr. Linda Hawes-Clever, an internist from California and the editor of the *Western Journal of Medicine*.

After the keynote speaker, the following five workshops are planned:

- **Medical Marriages:** The purpose of this workshop is to introduce, discuss, and seek solutions to the challenges that arise when one or both partner(s) in a marriage is a doctor. A panel of four physicians and their spouses will participate. Susan Heitler, Ph.D., an expert in conflict resolution, will moderate this workshop.
- **The Glass Ceiling:** Harvard psychiatrist Sharyn Lenhart, MD, will explore the obstacles women encounter when advancing in careers traditionally dominated by men.
- **Impact of Careers on Children:** Helen Bucksbaum, Ph.D., will examine the challenges professional parents face when raising their children.
- **Team Management:** Les Wallace, Ph.D., founder and president of Signature Resources – an international management consulting firm – will explore ways to enhance productivity and satisfaction in the workplace by creating a team environment. His style of management utilizes proactive, coaching techniques.
- **Effective Speaking Skills:** Dennis Phillips, Ph.D., Associate Professor of Speech Communications at Colorado State University, will lead this workshop. Participants will have three to five minute speeches videotaped and analyzed by Dr. Phillips.

This conference promises to be an empowering experience for all participants. Please mark your calendars and watch for the upcoming flyer with more details and registration information, or call Cindy Wooley at 930-0419.



"The birth of the *BLUES*"

Blue Cross-Blue Shield of Colorado ... how far they've come to reach this point.

As our legislature deliberates over passage of SB 96-100 which will allow Blue Cross/Blue Shield of Colorado to change from a nonprofit to a for-profit stock institution, it may be opportune to review the history of that esteemed and sometimes maligned institution which has been such an important part of Colorado medicine for over fifty years.

The "Great Depression" of the '30s had created a health care crisis different than the crisis facing us today. It is difficult to remember or conceive of the social devastation of those "hard times" and the impact it had on the practice of medicine. Picture, if you will, banks closing with personal savings completely wiped out; farmers losing their farms through foreclosure; stock prices dropping to a fraction of their original value and the unemployment rate rising to 15%.

People could not pay their hospital and doctor bills and private medical care became a luxury only a few could afford. The country was in a mess. Enter Franklin Roosevelt and his band of liberal Democrats with the "New Deal". Despite revolutionary changes in the country and enormous expenditures, the depression obstinately continued for seven long years; the health care crisis deepened. And conservatives, including some physicians, learned to hate "that man" in the White House. As the health care crisis worsened, Senator Wagner of New York introduced legislation for a National Health Plan. This was ultimately blocked by the AMA's energetic lobbying. To counter the AMA's conservative position, a number of liberal physicians offered a set of "Principles and Proposals" for addressing the crisis. The principles and proposals supported the concept that the health of the people was the direct concern of the Federal government and that a national health policy should be formulated, allocating Federal funds for medical education, research and hospitals and establishing a new department where all health activities of the government should be coordinated. The committee obtained the signatures of over 400 physicians nationwide in support of their "Principles and Proposals" and asked each county society to endorse their plan. This created quite a stir in the medical community, and the threat of "socialized medicine" provoked the AMA House of Delegates into action.

On the local scene, at a December 7, 1938 meeting of the Denver Medical Society in the auditorium of the Capitol Life Building, there was a spirited discussion of the "Principles and Proposals of the committee of Physicians" by Mr. Harvey Sethman, executive secretary of the CMS, Drs. John W. Amesse, Tracy Love, William Crisp and J. J. Waring, Chair of the Department of Medicine at the Medical School. Dr. Amesse, our delegate to the AMA House of Delegates, presented a spirited defence of the position of the AMA, labeling as false the "widespread and unaccountable misconception..." that a small criteria of members have usurped the powers, rights and functions of the majority". He explained that, rather than develop a plan for the entire nation, the House of Delegates, in the 1934 session in Cleveland, after long debate, unanimously adopted a set of principles, ten in number, "which interprets the views of established medicine..... In brief, these principles contend that the practice of medicine should be under the exclusive control of the medical profession; that no third party should come between the patient and his physician; that patients must have absolute freedom of choice; that medical care must remain as a confidential relation and that all systems of relief of low income classes should be limited strictly to those below the 'comfort level'". He described these principles as so broad that "the way was opened for any county society to develop its own plan of action".



by John L. Lightburn, MD, Historian
Colorado Medical Society

Concerning the Principles and Proposals of the Committee of Physicians", Dr. Amesse described how this set of proposals had been rejected by the House of Delegates at the recent meeting in Atlantic City. "The conviction was strong among us that the allocation of Federal funds for the provision of medical care, for the support of medical education, for medical research or for the administration of hospital relief, however small the sum might be, would act as a ferment and soon permeate every activity in our professional life." Prophetic words!

While the medical society of Denver was occupied with these matters. The eight hospitals of Denver, concerned about empty beds and unpaid bills, had been meeting to develop a group hospitalization insurance plan. They patterned their plan after Blue Cross plans in other states, the first of which had been established by Baylor University Medical School for the school teachers of Dallas, Texas, in 1929 (a policy providing 21 days of hospitalization for a modest \$6.00 per year).

After consulting with the Denver Medical Society, they began selling their Blue Cross plan to groups in Denver and after one month had 15 groups with 1000 members. The May Company was the first group to enroll. A year later, over 500 groups had enrolled representing 20,000 subscribers. William S. McNary was the first president and the first directors were John R. Mulroy, Frank J. Walter and Walter G. Christie. Thus the Blue Cross plan was born

in Colorado.

Much earlier, in 1917, the doctors of Tacoma, Washington, developed a medical insurance program for the people of Pierce County. Although they called it a Medical Service Bureau, it was the prototype of various plans that later became Blue Shield plans. The Denver Medical Society, knowing they had to provide an alternative to the feared National Health Plan, assigned committees to work on the problem. In his presidential address in January, 1938, Dr. William W. Haggart said "A counterpart, but absolutely independent of Group Hospitalization,is the Central Service Bureau, This, I remind you, is not open to anybody except the low income group However, the exact construction and working of this plan will be worked upon this yearProbably the most important single requisite for the working of a central Service Bureau is that the doctors cooperate and not deplete the fund by charging exorbitant feesShould this plan be worked out, it is the responsibility of each and every doctor of the society to guard this fund..." What would have been the outcome if President Haggart's admonition had been followed?

After three years of hard work and negotiations, the Colorado Medical Service was incorporated in 1942 as the Colorado Blue Shield. Dr. John W. Amesse became the first President. In partnership with the Colorado Hospital Service, it became the dominant force in the medical insurance field in Colorado. Their growth eventually necessitated

the building of their current office building at 700 Broadway in Denver. In 1978, the two companies merged and became Blue Cross and Blue Shield of Colorado.

Through the work and struggles of men and women of good will, an effective and fair system of payment for medical care evolved. It seemed to work until the escalating costs got out of control. Hopefully, our profession will again rise to the challenge and bring forth a new solution to our current crisis.

IBM/Blue Cross-Blue Shield of Colorado ... what next?

What can possibly happen next in this colorful history? "The Blues" are now collaborating with a major international company to produce an entirely new slant on medical practice. We'll be watching this development carefully and report in future issues about the results.

Editor



Recent Affiliations and Mergers (in Colorado healthcare)

Prepared by Lorraine Heth, Program Manager
Colorado Medical Society Department of Health Care Policy

Key: DP = Denver Post; CMC = Colorado Managed Care Newsletter; RMN = Rocky Mountain News; DBJ = Denver Business Journal;
WSJ = Wall Street Journal; C/M = Colorado Medicine

"The practice acquisition frenzy is part of a broader industry consolidation..."

• Primera Healthcare, LLC

Primera Healthcare, LLC announced on February 10, 1996 that 65 primary care physicians and their practices have joined the organization since January. Most of Primera's newly employed physicians are veteran practitioners with successful, long-term medical practices located throughout the Denver metropolitan area. As Primera physicians, they will share in the governance of Primera. Primera's two sponsoring organizations are Lutheran Medical Center and Sisters of Charity of Leavenworth Health Services Corporation, the parent organization of Saint Joseph Hospital.

(Source: Primera Healthcare 2/15/96)

• Kaiser Permanente of Colorado

Lutheran Medical Center and Swedish Medical Center are the two finalists on Kaiser Permanente of Colorado's short list for a new hospital partner in the metro area. (RMN 3/13/96)

• Columbia-HealthONE

Columbia-HealthONE announced that it has hired a management firm to take over operation of eight senior citizen health centers owned by Columbia HealthONE. GeriMed of America Inc., a Denver company that operates 15 MedWise health-care centers for seniors nationwide will manage the centers. (DP 3/6/96)

• CareNet LLC

Three Colorado home health-care providers have joined forces to create the state's first independent company that offers comprehensive home health services. Denver-based CareNet LLC, which started in January, unified the resources of three people whose companies already served various home health needs in Colorado: Kay von Metzger, president of Colorado Home Care Inc.; John B. Henry, president of Medical Home Supply Inc.; and David Lamb, president of Professional Pharmacy Services Inc. (DBJ 2/23-29/96)

• Other News of Related Interest

The number of Colorado health maintenance organizations has jumped by 50% in the past year and the number of physician organizations seeking contracts with those insurers increased by nearly as much. The number of HMOs grew from 12 to 18 in the past 12 months while the number of physician organizations — typically groups of primary care or specialty doctors — grew from 54 to 76, according to the ninth annual Directory of Colorado Managed Care Organizations. According to the report, 20% of the state's 425,000 Medicare recipients are enrolled in HMOs and 22% of the Colorado Medicaid recipients are in HMOs. That's one reason for growth in the number of HMOs, said Hertel. (RMN 2/23/96)

IBM and the firm that manages Colorado Blue Cross and Blue Shield, Rocky Mountain Health Care Corp., announced they've teamed up to form a computer network to expedite health-care claims processing by five to 10 days. It will be run by IBM and will link health-care providers, such as physicians, clinics and hospitals, as well as insurance companies (other than Blue Cross and Blue Shield) that pay claims. The system will permit users to get lab reports back electronically or access pharmaceutical databases, for example. The system is

expected to be up and running in September, according to Julie Barrington, a spokeswoman for Colorado Blue Cross and Blue Shield in Denver. **(DP 3/5/96)**

Under SB 96-100 Blue Cross and Blue Shield of Colorado and other nonprofit Colorado health-care companies would be allowed to convert to for-profit, stock status. Jack Ehnes, Colorado Insurance Commissioner, however, will not approve a conversion plan which rewards directors, officers or employees for accomplishing the conversion. The bill would require the Division of Insurance to approve any Blue Cross application to convert to for-profit status. **(DP 3/7/96)** SB 96-100 would require Blue Cross, in converting from non-profit to for-profit status to transfer its assets to a charitable foundation, which would hold the majority of the for-profit company's stock. The transfer would take place because, as a nonprofit company, Blue Cross for years enjoyed tax breaks that for-profit competitors didn't.

(DP 3/14/96)

Sandoz and Ciba-Geigy plan to join forces. The two Swiss drug and chemical companies are rushing into each other's arms in a \$27 billion-plus merger. Cost-containment efforts by national governments and managed care organizations have squeezed profits and forced an extensive industry restructuring. Through mergers and acquisitions, companies have combined product lines and slashed costs, giving them both improved profitability and more marketing muscle. Analysts predict at least 40% of its U.S. sales will be lost to generic rivals this year. Glaxo's chief executive, Sir Richard Sykes, said in an interview that he expects mergers to be increasingly common among top makers for the rest of the decade. **(WSJ 3/7/96)**

• Trends

Nationwide, thousands of doctors are being wooed like free agents by companies offering big money for their practices. With 19 publicly traded practice-management concerns already in the business, dozens more are preparing for public offerings, drawn by projected 40% annual growth rates for comparable companies and soaring stock values. "There's going to be a zillion of these things," says Robert Daly, managing director of TA Associates, a Boston investment-banking concern. At stake is command of the nearly \$800 billion in annual health-care spending that physicians either control or prescribe.

In a bid to regain lost influence and income by joining forces with corporations, physicians are entrusting their futures to emerging companies in an industry buffeted by price pressures and ownership changes. Many have to renegotiate their employment contracts every five years and, if the relationship turns out to be an unhappy one, some doctors are contractually barred from opening new offices in their old markets.

The practice acquisition frenzy is part of a broader industry consolidation spawned by the rapid spread of managed care. Doctors remain a fragmented, fiercely independent lot, with about half of the nation's 680,000 physicians working as solo practitioners and less than a third in group practices of three or more doctors. Meanwhile, a doctor's reputation and referrals from other physicians are becoming less powerful income generators than managed care contracts.

Some companies manage thousands of primary-care physicians, and others specialize in niches. While some run a practice's business for a percentage of revenue, others buy practices

outright, paying cash and stock for buildings, equipment and accounts receivable. Physicians often get a guaranteed salary—commonly about what they currently earn or even as much as 20% less—for up to five years, along with incentives to retain existing patients and attract new ones.

In Florida, hospitals jumped into the market, fearing the practice-management companies would seize control of doctors they depended on for referrals. Haggling erupted over hundreds of practices, as former health-care executives, hospital administrators and even stockbrokers became "practice brokers" who scouted for acquisition candidates or herded single practitioners into small groups with sales potential. Prices were all over the map. "I've seen the same practice being offered \$250,000 on an all-cash basis and \$1.2 million on an all-cash basis," says Ira Coleman, a Miami attorney.

The South Florida doctors who sold out in the early days of the boom generally profited most. But the money hasn't been all that great for some doctors. The upfront money paid for practices has fallen to as little as \$100,000, and a few doctors have hired lawyers to get their practices back. Steven Scott, president and chief executive officer of Coastal Physician Group, Inc., wonders just how far the stock market, with its inherent pressure for earnings growth, should reach into the examining room. "Physicians know how much of that profit is reasonable to drop to the bottom line before you truly start to impair care," he says. "I'm not sure that Wall Street does."

(WSJ 3/12/96)

Taking managed care on the air:

by Chet P. Seward
CMS Communications

Canadian radio searches for answers in Colorado



Joel Karlin, MD (left), former Gov. Dick Lamm (center) and Jim Hertel at Denver KCFR studios, on the air to Canada.

Colorado's sweeping changes in health care reform have perked the curiosity of potential reformers in Canada. In a segment of a nine-part series on managed care in the U.S., a Canadian Broadcasting Corporation (CBC) program known as *The Eyeopener* will analyze the differences between the nationalized care of Calgary, Alberta and the highly privatized care of Denver.

Two panels of Colorado health care professionals addressed health care reform issues during taped discussions at Denver KCFR studios. These interviews will be broadcast on upcoming *Eyeopener* shows as well as by a sister station in Edmonton, Alberta.

A panel comprised of CMS President Joel Karlin, MD, former Colorado Governor Dick Lamm and Jim Hertel, President of Health Care Computers of America discussed recent health care trends in Denver.

In response to the recent federal push for reform, numerous private initiatives have overhauled the industry, including a 50% increase in HMO enrollment, projected Medicare and Medicaid reform and a considerable contraction of providers. Hertel said that the delivery of care has placed more emphasis on outpatient services and transformed care into a commodity. Governor Lamm described the resulting "uncertainty, confusion and

dislocation as being part of a normal transformation". Dr. Karlin reported the fact that the cost of care has become a driving factor. He believes that "the system has depersonalized itself...and moved away from the cornerstone of medicine, which is the doctor-patient relationship" by allowing selective contracting by employers.

All three panelists think that the evolution of health care will continue. Governor Lamm is impressed with the Canadian system, but believes that such a system is not politically feasible in America. Hertel was concerned about Canada's inability to financially support high technology health care. He believes that competition, as witnessed in the emerging growth of large networks in Denver, is an essential ingredient to any system. Dr. Karlin was also impressed with primary care in Canada, but was concerned about the availability of specialty care. He stressed the importance of primary care and specialty care physicians working together to make a continuum of care in which the patients become informed health care consumers. All three agreed that the quality of care will not necessarily be compromised as costs are controlled.

Leigh Truitt, MD and Larry Wall, Colorado Hospital Association President discussed the effects of managed care on hospitals in a second panel.

The Denver area has experienced a dramatic consolidation of hospitals due to employers' demands for increased competition. Patients have fewer choices as a result.

Inpatient services have also decreased, while outpatient services have increased.

According to Dr. Truitt some physicians have been financially hurt because market forces have expanded the use of capitation. He believes that quality has not been compromised because physicians must continue to provide high caliber care in order to remain in provider

networks. Consumer satisfaction gauged by outcomes studies will underscore assurances of quality care. Wall was quick to point out that it is difficult to discern if quality of care has been affected. Without

objective, standardized means of measuring outcomes data there is only anecdotal evidence suggesting a change in care. More work needs to be done to manage and standardize outcomes data studies.

Both agreed that hospitals and physicians will prevail if their quality is high and their prices are right. It will take time to adjust to an environment where consumers do not have complete choice. Dr.

Truitt noted that "consumers are beginning to understand that wide-open choice is expensive," and Wall added that "consumers are adjusting to changes in their choices". He carefully pointed out that while

consumers have equated high quality care with excessive care, managed care is providing "appropriate" care. In this way patients are receiving only the treatment they need and not the treatment they want. Wall believes that this minimized access to care should not be viewed as being negative, because it is a different mode of delivery which prevents excessive tests and costs.

Both panelists concluded that the implementation of managed care should be a deliberate, gradual process. Dr. Truitt cautioned Canada not to "leap in with both feet". He suggested using a 1975 Colorado HMO as a model for change. In that way the process could begin gradually, as a system Canadians can tolerate. As the need arises, more cost containment can be implemented. Wall stressed that it is critical to keep consumers informed. He suggested that Canada develop an information data base for consumers before the system evolves too much further.



Larry Wall of Colorado Hospital Association (Left) and Leigh Truitt, MD, discuss Colorado health care reform issues on Public Radio.

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Dizzy with possibilities

by **M. Ray Painter, MD**
President-Elec
Colorado Medical Society

Health care and the Information Age

"We don't have to throw the baby out with the bath water, but we do need to become more informed"

As the Colorado Medical Society gears up to celebrate its 125th anniversary in September, it is important to consider the past, present and future of Colorado's medical profession. As this edition of *Colorado Medicine* explores the "Electro Doc" theme, it seems particularly relevant to ponder how technology has improved the delivery and access to health care. It is critical that we, as an organized society of physicians, embrace these technological innovations and play a guiding role in prudently implementing them.

Any of you that know me know that I am not advocating a complete upheaval of the status quo. We don't have to throw the baby out with the bath water, but we do need to become more informed. As the needs of our patients and the public change, we physicians must raise our standards to provide even better care. Like it or not the good old days of \$10 house calls are gone. Those days have been replaced with the micromanaging trends of managed care. It is our duty to be aware of and utilize technology that can provide the most cost effective, quality care to our patients.

I know that change is difficult, and it does not happen overnight. Please read Sandi Maloney's update this month as well as Dr. Dwoskin's and Dr. Waite's features on medical informatics. Think about how technology is affecting the practice of medicine for better or for worse. Discuss these issues with your colleagues and then let me or the CMS Communications Department know what you think.

That was then this is now

I read an article a couple of weeks ago that celebrated the birthday of the first computer. It was a mammoth monster that took up a whole room. Today a semiconductor chip smaller than a fingernail can do the same job thousands of times faster. The same is true with technology in health care.

The telecommunications revolution is in full swing. Applications like video-conferencing, video-imaging and high definition television have increased the credibility of telemedicine. The ethical, financial and political hullabaloo continues over this practice. But telemedicine will undoubtedly revolutionize rural medicine and shorten the gap between urban and rural practice standards.

The Internet and other electronic data interchange technology has re-invigorated the prospects of an electronic patient record. Such a record could help control costs, expedite quality care and facilitate the emergence of an integrated continuum of care. Here too, concerns must be addressed and caution must be exercised.

Managed care and the public are clamoring for outcomes data. Physicians must lead the way to find and utilize technologies that will create a standardized application.

"Dizzy with possibilities" aptly describes these times. **Physicians must take a leadership role now in addressing technological advancement issues in health care.** What do you think?

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Advances in Medical Informatics

A giant leap for medicine

by Joseph Y. Dwoskin, MD
CMS Office Automation Task Force



"Understanding the principles of the process and the equipment needed is a project for all of us."

The modern medical office requires computers to handle a vast array of information. Computers gained wide acceptance by processing billing, appointments and prescriptions. However, computers can and should do much more to improve the efficiency and quality of health care. Security and confidentiality are still issues related to many new applications. These relevant concerns must be addressed. In the meantime, **steps should be taken to educate and inform physicians of the advances in medical informatics so that the medical profession will benefit.**

Instead of rummaging through an unorganized patient record in a manila folder, imagine clicking a mouse button to retrieve a patient's complete medical history with physician notes, diagnoses, lab tests and prescriptions all on one screen. Stop dreaming. Such systems already exist. The electronic medical record (EMR) is concise, coordinated and usually current.

Outcomes data, which is quickly becoming necessary in the practice of medicine, will be more accessible and will be a beneficial tool for both patients and physicians.

Telemedicine proves its usefulness daily in rural settings where access to care was once limited. The use of video-conferencing and video-imaging is proving invaluable for simple things like continuing medical education. Complicated exercises, like participating in examinations, are also possible.

The Internet is now available to anyone with a computer, modem and the correct software. This

resource provides vast amounts of usable information and is becoming a common part of many practices. E-mail keeps doctors up to date and in touch.

The Office Automation Task Force is currently working on the CMS Home Page for the Internet. It will be a place where members can rapidly link and obtain information from all over the world. There may be many other useful member services in this area, including communicating with CMS by E-mail. There may also be a patient section on the home page. This might be a place where patients can get information about member physicians, where and what they practice, and as a public service, where medical information can be obtained by subject in a limited manner.

Understanding the principles of the process and the equipment needed is a project for all of us. Most young physicians are computer literate, needing these tools in school and residency. Those of us who are more senior, have been reluctant, or too busy, to learn how to use these machines. It is essential that we physicians embrace the technology of the Information Age because the future of medicine lies with it. CMS and the Office Automation Task Force is committed to making this transformation possible and positive.

As the importance of the Information Highway increases, physicians must acknowledge the advances in medical informatics. The CMS Office Automation Task Force was charged with exploring and evaluating this burgeoning world.



by **H. Dennis Waite, MD**
CMS Office Automation Task Force

Look before you leap

Advances in Medical Informatics

As a member of the higher echelon of "cyberfreaks," I find the advances in medical informatics incredibly exciting. The Internet will increase communication between physicians and patients. Telemedicine has the potential to revolutionize the profession in rural areas. Standardized, credible outcomes data, while still a long way off, will undoubtedly improve the quality of health care. However, in light of these advances, I think that it is prudent to exercise caution. There are specific concerns about confidentiality, privacy and data security which must be addressed.

Historically, we have stored medical information and filed health insurance claims on paper. This process is both cumbersome and expensive. "Ironically, it is this 'negative' aspect of the paper medium (its cumbersome nature) that has minimized the risk of breaches of confidentiality."¹ The potential for easily retrieving confidential information is limited by the difficulty of reviewing large numbers of records.

In interviews with patients, most are quite trusting that physicians will not abrogate this part of physician-patient relationship. There are some very explicit laws, variable from state to state, limiting access to records pertaining to issues such as HIV or substance abuse. In the information age, how are doctors going to protect their patients' information when it could potentially be accessed by unauthorized persons, in unlimited amounts, with a much less cumbersome process?

Security measures you say! Limited access based on the "right to know" you say! Who decides what information should be available and to whom? Traditionally, only the patient can consent to release the information. As physicians, we are the primary trustees of the information. Release of that information to secondary repositories like large central databases, clearinghouses, insurers or managed care companies *should* obligate them to the same standards of release. But will it? I worked in an insurance company and could daily walk by computer screens left open to the main data, or more interestingly, with the passwords written on post-it notes attached to the computer frame. How good are current security measures?

What about the patient's right to know what information is contained in the database record? Shouldn't patients have a right to examine the data and make corrections if they feel the information is inaccurate? A 1993 Harris poll found that the vast majority of the public favors significant attention to the issues of privacy, confidentiality and security of medical information in any electronic data system. Ninety-six percent support legislation that designates all personal medical information as sensitive and imposes penalties for unauthorized disclosure.² These are some of the issues that we as physicians must explore. Shouldn't we, as members of a physician's organization, take a leadership role in monitoring these developments?

"Release of that information...should obligate them to the same standards of release. But will it?"

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Rural Health

Jack Berry, MD, Chairman

Colorado Medical Society

Rural Health Care Task Force



The mission continues

"There are many challenges for rural communities and rural physicians . . ."

The Colorado Medical Society **Rural Health Task Force** continues its mission to improve quality health care for rural areas. The focus of attention has been on the legislative effort to draft and pass the rural practice incentives bill (HB 1073). Members of the Task Force have worked hard to produce meaningful legislation and with the assistance of the Department of Governmental Affairs, we have done just that.

HB 1073, the rural physician, physician assistant, and advanced practice nurse recruitment and retention bill was heard the week of February 12 by the House Finance Committee. The goal of the bill is to improve access to quality health care providers in rural areas. It was approved in House Finance, and was sent on to the House Appropriations Committee where it will be heard sometime in April.

The bill proposes a loan repayment incentive for physicians, physician assistants and advanced practice nurses. Initially a tax credit portion was contained in the bill, with the hope that such an incentive would further persuade rural practitioners to remain in their settings. Given the current political climate of the legislative session, it was determined that removal of the

tax credit portion of the bill would increase the likelihood that the loan repayment portion of the bill would pass. Richard Krugman, MD, Dean of the University of Colorado School of Medicine, and I provided testimony on behalf of this bill at the House Finance Committee hearing. Lindy Nelson, MPH, of the Colorado Department of Public Health and Environment, was also present to answer questions.

Other efforts are also beginning to reap benefits. Last summer, Mark Deutchman, MD, Director of Advanced OB training at the University of Colorado School of Medicine, and members of the task force developed a rural practice survey. It sought to determine how doctors are practicing in rural areas, which areas are truly underserved and what training would be helpful in family practice residencies specifically geared for rural areas. 585 surveys were sent, and 150 were returned. The data has been compiled and will be used to assist the Task Force and other rural health agencies in furthering the goal of improving access to health care in rural areas.

The Task Force continues to build coalitions with organizations that focus on rural health care issues. CMS met with representatives from the University of Colorado School of Medicine to discuss the legislation, the survey and training and re-training issues. Representatives from the medical school made a commitment to diligently work to expand rural practice training opportunities. These models may include a rural training track at the medical school, fellowships, designation of a spe-

cialty in rural medicine and increased participation in rural training efforts by rural physicians' offices. The group will meet again in the near future.

There are many challenges for rural **communities and rural physicians**, not the least of which is gaining access to the technology which can make rural practice more efficient and more effective. In the coming months the Rural Health Task Force will begin to explore the issues surrounding these technologies. Our hopes are to provide our colleagues with the information they need to make educated decisions about what works best for them and their communities.

From windmills to computers

There has, for years, been an invisible wall between urban and rural medical practice; not between physicians themselves, but separating the practice modalities and public attitudes. Rural physicians have, in a great sense, been cut off from much of advancing medical technology and continuing medical education simply because of their specific geographic and clinical environment.

Today's technology is reaching into the rural practice areas, but slowly. Witness the growing number of physicians' "e-mail" addresses. Will there be speedy acceptance to "telemedicine" when it breaches the wall and poses the danger of changing the role of the rural physician? We'll examine the questions in future issues

Editor.



CAPITATION: Pros, cons and ethics

The big casino! Capitation! Should you, or should you not? Or do you have a choice? Surprisingly, capitation is not as common as you might think.

Deborah Gesenway, *"Is it all hype? Capitation is still an illusion for many,"* ACP Observer, p. 1, February, 1996.

Capitation can benefit both health plans and providers. Many observers recommend that physicians retool their practices to accept risk and reap the benefits of utilization management. Medical groups in California have been very effective in managing risk and controlling utilization.

Lauren M. Walker, *"Turn capitation into a money-maker,"* Medical Economics, pp. 58-71, March 15, 1995.

James C. Robinson and Lawrence P. Casalino, *"The Growth of Medical Groups Paid Through Capitation in California,"* The New England Journal of Medicine, 333:1684-1687, December 21, 1995.

"The Game of Risk," Modern Healthcare, pp. 24-29, February 5, 1996.

Managing capitation risk does require thought and preparation. Furthermore, it requires the ability to lay off some of the risk through the use of stop loss insurance.

Edward Doyle, *"Medicine on 36 cents a day: How to take the fear and risk out of capitated payments,"* ACP Observer, pp. 13-14, March 1995.

Deborah Gesenway, *"Capitation; how not to lose your shirt,"* ACP Observer, pp.10-11, November, 1995.

Just as fee-for-service may create financial incentives for over treatment, capitation provides inducements for under utilization of resources. The following articles address these issues:

Council on Ethical and Judicial Affairs, American Medical Association, *"Council Report: Ethical Issues in Managed Care,"* Journal of the American Medical Association, 273:330-335, January 25, 1995.

Marc A. Rodwin, *"Conflicts in Managed Care,"* The New England Journal of Medicine, 332:604-607, March 2, 1995.

Katherine Swartz and Troyen A. Brennan, *"Integrated Health Care, Capitated Payment, and Quality: The Role of Regulation,"* Annals of Internal Medicine, 124:442-448, February 15, 1996.

Harry P. Selker, *"Capitated Payment for Medical Care and the Role of the Physician,"* Annals of Internal Medicine, 124:449-451, February 15, 1996.

If you cannot obtain copies of these articles through your local medical library, please call Lorraine Heth at the Colorado Medical Society for reprints at (303) 779-5455 or 1-800-654-5653.

Leigh Truitt, MD



School of Medicine: At an Important Crossroads

by Richard Krugman, MD
Dean, University of Colorado
School of Medicine



Midway through what must be one of the more difficult decades for academic medicine, the University of Colorado School of Medicine not only is surviving, but by most objective measures, thriving. That, however, does not mean we should be complacent.

There are a number of reasons for this success. First, and foremost, we are blessed with a superb faculty that remains highly competitive in securing research funding, in generating clinical earnings and in educating our students. Also, our administrative infrastructure of chairs and center directors are, for the most part, academic leaders of the highest order.

We are also blessed geographically. As the only School of Medicine for 500 miles, we don't have the same struggles as do many other medical schools that compete for patients with another school across town. Finally, there is continued harmony on the Health Sciences Center campus between the Board of Regents, the Chancellor, deans and the president of University Hospital, something which was missing for several years.

In the research area, the School of Medicine currently ranks eighth among all public medical schools in NIH funding, putting us in the top six percent, and 19th among all medical schools, which ranks us in the top 15 percent.

I believe we will continue to be successful in the research arena, which is critical to the University of Colorado Health Sciences Center. We intend to continue to invest heavily in research. Currently, we

are discussing the allocation of funds to Molecular Structure, health services research, neurosciences, cancer and many other frontier areas of medicine.

Molecular Structure, for example, is expensive but important. This major research initiative is a good example of how things can work well, with collaborative support from such areas as Cellular and Structural Biology, Pharmacology, Biophysics, Biochemistry, Genetics and the Cancer Center. We were chosen by the Howard Hughes Medical Institute as one of 30 schools to receive \$2.4 million to help develop this area.

The School's clinical enterprise is also growing. Last year's clinical earnings through University Physicians, our group practice plan, were \$85 million. But with growth comes increasing challenges. Some would say we are living on the health care equivalent of the San Andreas Fault.

While research has been an important contributor to our stability, our survival also has been dependent on being successful on the business side. Managed care contracts have grown from seven in 1991 to 47 contacts this year, accounting for 22 percent of our gross revenues.

We are involved in several innovative approaches to serving additional populations. These include Colorado Access, a Medicaid managed care program; tertiary provider contracts with FHP and Kaiser; CU Care, providing for the medically indigent and veteran populations; and our own University of Colorado health plans.

In order to preserve our mission as a teaching institution, we also need to be productive and to respond quickly enough in a rapidly changing market. Our future as a school relies on our faculty's ability to function as a unified group practice, and we don't have much time to waste.

We have seen significant improvements in our educational experience over the past five years. Our three year longitudinal Primary Care Course has been well received by the students, faculty and our primary care preceptors. Other actions have included: a change in residencies through the shrinking of some specialist programs and expansion of primary care residencies in family medicine and general internal medicine; a continuing medical education program that continues to attract practicing physicians; and the Colorado Rural Health Scholars Program for rural and underserved high school students.

The medical school's relationship with the Colorado General Assembly, in my opinion, has never been better. Relations between the School and the Colorado Medical Society have grown increasingly close, as well. As for other constituencies, we need to strengthen ties with our alumni and clinical faculty.

Finally, we must not forget that the School of Medicine exists to educate medical students. It is our responsibility to take care of all our students, to be there for them, to be their home as a group of faculty. They are our future, and yours as well.

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INTERIM MEETING 1996

At the "96 INTERIM"

PROCEEDINGS OF THE HOUSE OF DELEGATES INTERIM MEETING 1996

The Colorado Medical Society House of Delegates met at the Holiday Inn Southeast, Aurora, Colorado, March 23 - 24, 1996 and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/ CONSTITUTION & BYLAWS

Adopted a Resolution that states physician participation in executions is a personal and moral decision, and that physicians should not be required to participate in an execution.

Adopted a Resolution that calls for candidates for the positions of AMA Alternate Delegate and Delegate to present their viewpoints in Colorado Medicine and at a candidate forum at the Annual Meeting. The Interim and Annual Meetings are to include sessions in order to present issues and obtain input from members.

Adopted a Resolution regarding the care of dying patients.

Adopted a Resolution allowing for the expenditure of a certain amount of funds used to study the establishment of a student loan repayment program for rural physicians.

Adopted a Resolution regarding a Bylaws amendment to the Order of Business used at meetings of the House.

Adopted a Resolution to sunset outdated policy pertaining to ethical issues.

Adopted a Resolution on Ethical Issues in Managed Care, with the recommendation that the report be disseminated to all members.

Adopted a Resolution regarding the Physician-Patient Covenant, which essentially states that at the center of medicine is a moral enterprise grounded in a covenant of trust.

Adopted a Resolution calling for sunset of outdated administrative policies.

Postponed a Resolution regarding the Nominating Committee. A report will be brought to the House of Delegates at the 1996 Annual Meeting.

Accepted for filing:

- Progress Report - Colorado AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Executive Director
- Progress Report - Council on Ethical and Judicial Affairs
- Progress Report - Historian

PROCEEDINGS OF THE HOUSE OF DELEGATES INTERIM MEETING 1996

(Continued)

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Adopted a Resolution which states that the Colorado Medical Society will support the Colorado Revised Statutes on sex education in public schools, emphasizing abstinence to school aged children, as well as teaching "safe sex".

Adopted a Resolution recommending the Colorado Medical Society support the establishment of needle exchange programs.

Adopted a Resolution calling for the Colorado Medical Society to support the American Medical Association's efforts to achieve "all payor" funding for graduate medical education.

Adopted a Resolution that the Colorado Medical Society support instructions to increase the awareness of children on the dangers of firearms.

Adopted a Resolution which calls for the Colorado Medical Society to support comprehensive and incremental measures that will reduce the number of uninsured in Colorado.

Adopted a Resolution that the Colorado Medical Society believes that post-partum stays shall, in the opinion of the attending physician, be sufficient for the adequate recovery of mothers and newborns.

Adopted a Resolution resolving the Colorado Medical Society support and encourage immunization of children, adolescents and adults based on national standards, and that CMS work with various groups to support a dedicated preventive health care visit at 11-12 years of age.

Adopted a Resolution to sunset outdated and/or unnecessary policies on indigent care.

Adopted a Resolution that the Colorado Medical Society support the Medical Student Component's call for full disclosure of the National Resident Matching Program matching algorithm.

Adopted the Resolution calling for the Colorado Medical Society to oppose mandatory Workers' Compensation Level I accreditation for physicians.

Adopted a position paper on Medicaid.

Referred a Resolution to amend the Medically Indigent Policy to Health Affairs Council, for report back at the 1996 Annual Meeting.

Referred a Resolution regarding out-patient pharmaceutical formularies to the Board of Directors for decision.

Referred a Resolution regarding adjustment of the number of United States residency positions to the Board of Directors for study, and a report back at the 1996 Annual Meeting.

Accepted for filing:

Progress Report - Health Affairs Council
Progress Report - Council on Legislation
Progress Report - COMPAC



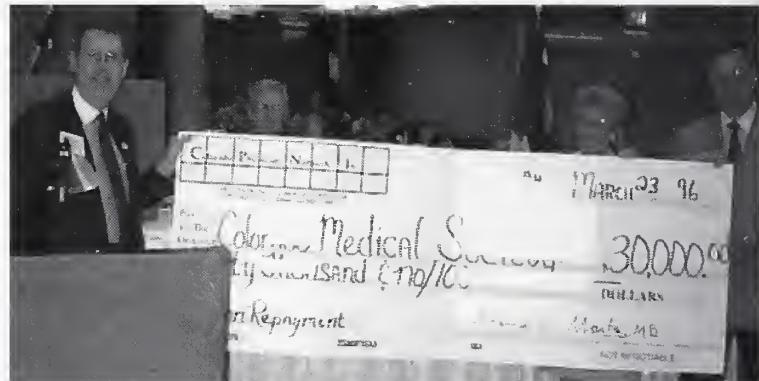
INTERIM MEETING 1996



A working luncheon on Saturday, March 23rd, attracted 150 persons to hear American Medical Association (AMA) President Lonnie Bristow, MD, report on the activities of the Association.

There recently had been some talk among Colorado physicians about the effectiveness of the AMA. This, coupled with the fact that Colorado has lost members in the AMA, caused people to sit up and take notice when Dr. Bristow agreed to address the Interim Meeting attendees.

A panel discussion concerning the state relationship with the AMA took place following Dr. Bristow's address.



David C. Martz, MD, President of the Colorado Physician Network (CPN), and Joel Karlin, a member of the CPN Board, presented a "big" check to CMS during the Interim Meeting. Almost hidden by the check is CMS Executive Director Sandi Maloney.

Martz turned over a check for \$30,000.00 as repayment by CPN for the loan from CMS which served to start the network organization last year. The check was big, and it was a big moment for Martz, who remarked that in less than eighteen months the organization had signed over 2100 physicians, developed a statewide presence, had created a company and a company identity, and was ready to offer its first product. All that after the concept had early on been turned down by CMS but then was brought to life by volunteer contributions.



Lilly Klancar, MS, received the CMS-MSC Leadership Award for 1996 at the 1996 House of Delegates. CMS President Joel Karlin presented her with the certificate and a check for \$500.00.

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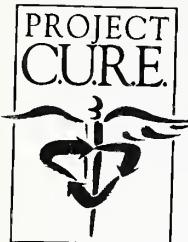
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Saving lives through medical surplus

Sometimes grand visions of philanthropy start out small. So it was with world renowned international economist Jim Jackson, when he founded Project CURE (Commission on Urgent Relief and Equipment) in 1987. Today hundreds of tons and millions of dollars of medical supplies and equipment have helped save thousands of lives in third world countries all over the globe.

Jackson's strong suit has always been seeing the big picture. Worldwide recognition made him a prestigious international economic consultant after he wrote a book on basic economics in 1982. It was during one of these consulting visits to Brazil in 1987 that Jackson's life changed forever. He saw long lines of people standing in the hot sun waiting to get into a medical clinic or hospital. It wasn't until later that he learned that even though they patiently waited their turns to get into the clinic, there would probably not be adequate medical supplies or equipment to meet their needs. Jackson was prompted by the pictures of dire social and physical need to promise the head of the clinic that he would return to the States to seek help. Project CURE was born.

The operation has miraculously grown out of Jackson's garage into a large warehouse in southwest Denver. Officially Project CURE is a nonprofit corporation that collects and distributes donated medical supplies and equipment to underdeveloped countries. Unofficially Project CURE is an organization that



*Jim Jackson, Pres.
Project CURE*

understands that it is not going to solve the medical problems of the world. But it does realize that it provides hope and life to many that would die not from lack of care, but from lack of adequate supplies.

Project CURE relied heavily on volunteers to deliver over \$6 million worth of medical supplies and equipment to Belize, Romania, Bolivia, Israel, Uzbekistan, Brazil, Guatemala, Haiti, Kenya, Mexico, North Korea, Bosnia, Russia, Thailand, Ukraine, Burma and Zimbabwe last year. This year's efforts have generated even better results with a container full of supplies and equipment shipped out every week.

Jackson's connections in foreign countries have facilitated the process. First needs are assessed in a prospective country. Then a customized shipment of donated supplies is assembled. At least \$5,000 must be raised to send the containers overseas. Jackson usually accompanies each shipment to expedite the customs process and ensure that the goods arrive at their intended destinations and not on the black market.

Technologically advanced market forces in America are the primary source for the second generation equipment and overstocked supplies needed by Project CURE. Horror stories abound in places like Kenya where a hospital that serves 60,000 people every month has only two thermometers

and patients regularly die because of infections caused by reused syringes and latex gloves. Almost no one questions the problem of medical waste in the U.S., yet hospitals routinely throw away or lease space to store their obsolete equipment.

The smallest donations to Project CURE are quite often tax deductible. Community involvement is the life-force of the operation. Volunteers from churches, women's groups and corporations sort and load supplies. A facility in Phoenix is now operational and plans to open a warehouse in southern California are being formulated.

While Jackson jokingly calls



Global shipments are stocked and tracked in the warehouse at Project CURE in Denver.

himself a "professional beggar", Rich Sweeney, MD, of Project CURE hopes that the vision of "saving lives through medical surplus" will spread across America. Anyone who participates in Project CURE knows that small ideas can have profound, lasting impacts.

To volunteer or for more information on Project CURE please call (303) 727-9414.



Patti Brown, President 1994-1996
Colorado Medical Society Alliance



The Year in Review

At its Annual Meeting in April, the Colorado Medical Society Alliance (CMSA) will install its new officers for 1996-97. They are: Stella Shanks, President, Sonja Unrein, Secretary and Mary Jo Ryals, Treasurer.

This year with the help of the County Alliances and the able assistance of the CMSA Chairman, Jo Netz, CMSA has collected \$18,288.13 for AMA-ERF.

The State Alliance took part in the nationwide antiviolence campaign entitled – **SAVE** – Stop America's Violence Everywhere. 700 "Don't Suffer in Silence" posters were produced with information on domestic abuse, along with places and phone numbers for victims to get assistance they need to stop the cycle of violence. The response to this project has been phenomenal. Sonnie Talley (SAVE Chairperson) is currently defining the campaign for next year.

The County Alliance members around the state have also been very busy. The following is an overview of their activities.

The Boulder Alliance assisted the SAVE campaign by developing school curriculum to teach conflict resolution skills. The Alliance also had Boulder Police officers talk with elementary school children about the problem of violence.

The El Paso and Pueblo Alliances helped with the SAVE campaign by sponsoring billboards. They also distributed "No Abuse" pamphlets and "I Can Choose" workbooks.

The Larimer Alliance contributed \$1,000 to keep the Centennial High School site based Health Clinic open. They also contributed \$2,800 to the Children's Clinic to develop and distribute communication tools to explain health services available in Larimer County.

The Longmont and Otero Alliances sponsored community blood drives and raised funds for AMA-ERF.

In addition to coordinating a courthouse vigil, the Mesa Alliance sponsored "An Evening on Main Street." 32 merchants and restaurants participated by donating a percentage of purchases made that night to benefit the SAVE program in Mesa County. \$2,000 was raised.

The Metropolitan Denver Alliance assisted the SAVE Campaign by sponsoring a Candlelight Vigil at Denver's City and County Building in October. Efforts to purchase and distribute "I Can Choose" workbooks continue.

The Montrose Alliance distributed the "Don't Suffer in Silence" posters to their community. They also raised \$3,000 for medical scholarships and helped put on the Fall Clinics for area physicians.

Stella Shanks will soon be installed as the new CMSA President. I wish to thank all of you for your help and support during my two years as President. I have enjoyed the experience immensely, in part, because I represented an organization that is "making a difference" in its communities, and because the experience has enriched my life immeasurably.

"... the experience has enriched my life immeasurably."



Alliance Day at the Capitol

Another strong showing of support



CMS Government Relations Division Director Lorraine Koehn addresses the CMS Alliance "Day at the Capitol" participants, providing an update on current issues and standings.

Organized medicine's voice was heard and its presence felt at the State Capitol.

In late February, the *Colorado Medical Society Alliance* held its annual "Day at the Capitol". With the help of CMSA members and the CMS Government Relations staff, over 60 physicians and spouses, along with students and teachers from Cheyenne Mountain High School (Colorado Springs, Co), attended the successful event.

Morning activities commenced with a legislative update by CMS' Lorraine Koehn and lobbyist Jerry Johnson in the former Supreme Court Chambers. AMA Regional Political Director Jay Keese then presented a review of how the AMA is helping physicians deal with the dramatic changes in the health care sector. Keese stressed the importance of grassroots support for legislative reform. He concluded by giving a few suggestions on how to effectively lobby legislators.

Attendees then received an up-front and personal look at the Legislature by viewing action on the House floor. Fortunately the legislative session did not run long, allowing many legislators to attend the luncheon that was hosted by CMSA.

Among the legislators attending were: Senators Sally Hopper, Richard Mutzebaugh, Frank Weddig, Charles Duke, Pat Pascoe, Ed Perlmutter, and



F.A. "Gus" Garcia, MD, (l) and Jay Keese of the AMA discuss issues in the chambers at the Colorado State Capitol.

Tillman Bishop, Representatives Pat Sullivan, MD, Joyce R. Lawrence, Martha Kreutz, Mary Ellen Epps, Doug Lamborn, Bryan S. Sullivant, Benjamin Clarke, MD, Robert Hernandez and Speaker of the House Chuck Berry.

CMSA wishes to thank all those who participated in Alliance Day at the Capitol. Encouraging grassroots support for the legislative effort is critical as the profession of medicine continues to grapple with health care reform.



Participants shown at luncheon, (l to r) Sen. Frank Weddig, Rep. Martha Kreutz, Rep. Ben Clarke, MD and Sen. Tillman "Tilly" Bishop.

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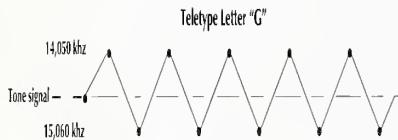
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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor



This month's feature subject, **"The ElectroDoc"**, reminded me of how far we've all come from some simple beginning where we knew nothing, did nothing, said nothing, until we learned by emulation or rote. Our instincts played a small part, such as telling us we must have food and rest; otherwise, we were just blobs.

Computer: a device that can store, process and retrieve data.

Fifty years ago I was fascinated (awed is a better description) by the teletype machine. This machine was widely used in the gathering and dissemination of news to newspapers and broadcasters. It was generally connected to *United Press*, *International News Service* or *Associated Press*, worldwide networks. Those commercial gatherers of news would send stories along to their subscriber-members on teletype, with frequent updates of the stories, 24-hour a day. One of my first questions was: "How do you tell an impersonal machine hundreds or thousands of miles away to strike typewriter-like keys to create a specific character in the alphabet, one after the other in rapid-fire motion, to create meaningful written communication?"

Think about this: you sit in front of a typewriter-like keyboard and you write a message by striking the keys. Almost instantaneously, your message is duplicated by a similar

machine at some far-off and invisible point on the globe. That is hard to comprehend, even today!

That was the forerunner of today's electronic and computer sciences which allow us to communicate, even "chat" with one another, via "E-mail" and Internet, to any point on the globe directly from our home-based computers.

For 37 years, I had one of the very early Model 12 teletype transmit-receive machines. My awe of 50 years ago wouldn't go away. Just last spring I gave it to the Gannett Communications Museum on permanent loan. Those machines worked on wired or wireless transmission systems, using what was called a "frequency shift-keying" (FSK) method of denoting characters. When you hit the letter "G", for instance, a signal generator would create a tone which shifted between 14,090 and 15,060 kh on the 20 meter shortwave band. "G" might, for example, require five shifts. The signal was then fed, high speed, to a transmitter and off it would go into the ether. If I had a short-wave receiver critical enough in tuning to capture that range of frequencies (which I did), I could receive teletype signals. Then, an "FSK" converter could convert these signals into intelligence which could actually be printed out on paper at a standard rate of about 60 words per minute. Awesome!

That's all rather a joke compared to what is happening in computers today; they're doing all this intelligence work on the same principal, except it is the shifting between two numbers, **0 and 1**, with all the data

analysis and transmission done in nanoseconds. In addition, we can copy and send pictures, graphics of all kinds, create original art and add sound and motion, and on and on.

As the *"Executive Director's Update"* in this issue puts it, we live in interesting times. I recently conversed with an acquaintance at *Silicon Graphics* (California), one of the world's leaders in computer communications development. He said the industry is poised and waiting with communication software that will sweep us well beyond the common man's imagination. . . . products **already developed** but waiting in the warehouse pending a decision by the master planners: *when will the market place be ready for the release of this newest wave of computer capability*. What does that mean? Simply this: *how quickly can consumers be up to speed on everything currently available so they're even able to comprehend uses for the new products?* In other words, computer research and development has outstripped the marketplace. Software developers are turning out so many new products that no one can sell fast enough to keep the public up to speed. Now that's heady stuff!

Will medicine be able to "catch up" to the pace at which these new sciences are propelling it into the future? Or will it be left in the dust of some multi-billionaire managed care firm which is willing to spend money on developing a fully-automated, robotic health care delivery system? Awesome!

That's a question no one can answer at this nanosecond in time.

PRESIDENT'S LETTER



*Joel M. Karlin, MD
President, 1995-1996*



A drop in the bucket . . . some would have you believe such a phrase depicts organized medicine's attempts to address the problems associated with managed care in Colorado. The flood of HMOs began about three years ago. As plans have consolidated and hospital systems have reorganized, the ripples have affected almost everyone. Without a doubt, disruptions in doctor-patient relationships have occurred. However, I don't think physicians are as helpless now as they were when the first wave of reform hit.

The tide is slowly changing, and CMS is playing a pivotal role. Public sentiment in favor of managed care has begun to ebb; health care is not just another commodity. Nor can it become another big business which is unresponsive to patient needs. This ethical conviction has been repeatedly expressed by public policy makers and the media. They look to us, the physicians of Colorado, to take the lead in helping them to correct some of those problems.

CMS has utilized three strategies to help solve those problems:
1) negotiation; 2) legislation and;
3) setting standards.

First and foremost, negotiation has been a critical tool. The creation of the CMS/CHMOA Joint Committee was a direct result of collaboration with the Colorado HMO Association in developing the "White Paper on Physician Affiliation/Disaffiliation". Members on both sides of the table are committed to addressing difficult issues like recredentialing, rural physician education, disclosing HMO financial

data and mandating lengths of stay.

In the past, when negotiations failed and further delays jeopardized patients or physicians, CMS has tenaciously pursued the Legislature. When contractual language prevented physicians from freely communicating with their patients, CMS responded by writing HB 1216. This bill, which passed the Colorado General Assembly and awaits the Governor's signature, bans "gag" clauses in physician contracts with health plans. The Legislature agreed that physicians should not be placed in the ethical dilemma of having to decide between the interests of their patients and the interests of a health plan.

The third strategy was to set the standard by which all health plans in Colorado will have to compete. Direct physician input has been assimilated into every operational system; many physicians and patients believe that the new Rocky Mountain Physicians' Choice plan (RMPC), created by the Colorado Physicians' Network and Rocky Mountain HMO, embodies the kind of proactive physician involvement in health plan development that must occur today. Utilization management systems will provide a new generation of managed care which fosters cooperation between primary care and specialty physicians. A continuum of care, in which physicians participate equally in decision-making, has been created. Physician profiling will be done with the most sophisticated technology available to create the best educational systems of care.

RMPC serves as a laboratory to

"... health care is not just another commodity. Nor can it become another big business which is unresponsive to patient needs."

test new ways of improving patient and physician satisfaction. Rural docs have already felt its impact. When another health plan solicited rural physicians in eastern Colorado, they had to change their contract provisions before physicians would even consider their proposal.

Physicians all over the country look to Colorado for leadership as they develop their own health plans and deal with managed care. CMS continues to demonstrate the strategies that are needed to navigate health care reform. In doing what is best for our patients, we do what is best for our profession. **The bucket is getting fuller.**

Call for Nominations

The Physician Award for Community Service, sponsored by Wyeth-Ayerst Laboratories, is designed to provide recognition to men and women who are actively engaged in the practice of medicine for the many and varied services above and beyond the call of duty which they render to their respective communities. The award was established in 1961 in appreciation for the time and personal sacrifice devoted by physicians to the welfare of their communities.

The Colorado Medical Society is now taking nominations for this award to be presented at the annual meeting in September. Nominees must meet the following criteria:

- 1) The nominee must be a licensed Colorado physician;
- 2) The nominee must be living; no posthumous awards are permitted;
- 3) The nominee must not have received this award previously;
- 4) The nominee must have compiled an outstanding record of community service.

Please help to promote the image of the medical profession in its ongoing efforts to be a positive participant in community life. Nominate a colleague today! Please call 779-5455 Ext. 2425 or 1-800-654-5643 for more details.

LEGAL UPDATE

Increasing Claims

Managed health care organizations are increasingly becoming targets of lawsuits. One of the leading decisions is the 1986 California case of *Wickline v. State*. In that case, the plaintiff was denied an eight-day post-surgery hospitalization requested by her treating physician. After discharge, she developed a severe infection requiring the amputation of her leg. Although the plaintiff's claim was denied, the court explained that third-party payors of health care services could be held liable when defects in their cost-containment mechanisms result in medically inappropriate decisions.

In response, managed health care providers have argued that public policy encourages cost-saving efforts and should limit their liability for such decisions. This argument may have initially resulted in the dismissal of a number of lawsuits, but certain court decisions have recently stated that no such policy exists. As a result, the number of successful cases is

expected to rise and such claims must be taken seriously. In the California case of *Fox v. Health Net*, a jury recently returned a verdict of \$89 million against the health care organization, after finding it responsible for the denial of treatment to a woman who died of breast cancer. In that case, evidence was presented that the person who made the decision to deny treatment to Ms. Fox was compensated in proportion to the amount of money he saved for Health Net. As a result, the jury determined that the refusal to provide treatment was profit-motivated, resulting in a substantial verdict.

All managed health care organizations and providers need to be aware of this growing area of law and take steps to limit their exposure to such claims. A complete risk management assessment should include a close look at all cost-containment procedures and statements of policy relating to the assessment of patients' requests for treatment. Programs involving goals or

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

financial incentives for physicians or other persons responsible for treatment decisions should be carefully considered. Caution should be taken to avoid language or policy provisions which suggest or could be construed to create undue influence against providing proper and necessary care.

Of course, certain treatments that are excessive in duration or cost, while having little or no therapeutic or remedial benefit, may not be unreasonable to deny. The focus should be on the mechanism by which such decisions are made, so as to avoid creating any direct or implied pressure on treaters to act contrary to the needs of their patients.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

Governor signs physician "gag" bill

Physicians and patients in Colorado scored a major victory on April 25 when Governor Romer signed into law HB 1216. Concerning the Prohibition of Provisions in Insurance Carrier's Contracts with Their Participating Health Care Providers (otherwise known as the "gag" bill) prohibits HMOs from placing language in their contracts with physicians which would explicitly or implicitly disaffiliate a physician for advocating appropriate care for patients. It will go into effect on July 1, 1996.

Sponsored by Rep. Martha Kreutz (R - Dist. 37) and Sen. Sally Hopper (R - Dist. 13), the bill passed the Legislature on March 28. The measure provoked



From left to right, CMS lobbyist Jerry Johnson, Richard Allen, MD, Joel Karlin, MD, and wife Caroline, M. Eugene Sherman, MD, (left front) Anne Beatty, Rep. Martha Kreutz, Sen. Sally Hopper and Catherine Benevides Clayton join Gov. Romer (seated) for signing of HB 1216 April 25th, 1996.

heated discussion and emotional testimony. CMS helped draft the bill after Dianne McAllister, MD, of Aurora, made the leadership aware of restrictions on physician-patient communication in a contract of a local health plan. Despite intense lobbying by the insurance industry, the Legislature agreed that physicians should not have to face the ethical

dilemma of deciding between the interests of their patients and the interests of a health plan.

In response to the passage of the bill, CMS President Joel Karlin, MD, affirmed "(that) nothing should ever impair the ability of physicians to counsel their patients for provision of appropriate care."

Dr. Howard scheduled for May CMS Leadership Conference to report on no-fault medical liability insurance system

K. Mason Howard, MD, former Chairman and CEO of Copic Insurance Company, has maintained a high level of activity in the professional liability insurance field since his "retirement". His principal interest has been in the development, analysis and feasibility of a no-fault medical liability insurance system.

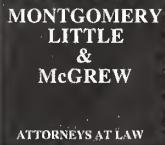
Dr. Howard will make a presentation at the CMS Leadership Conference, May 18-19, 1996, at Beaver Run Resort in Breckenridge, on the findings to date.

Howard reports of his studies that:

- By mid to late April researchers at Harvard School of Public Health will complete all data collection and analysis (Hospital injury data, malpractice claim/lawsuit findings, estimate of economic consequences of a no-fault system);

- It appears from preliminary analysis that the original goal of being able to impose an administrative system for medical injury within the dollar limit of current provider liability insurance costs will, indeed, be feasible;
- Among the various 'stakeholder' groups who will need to see and approve of the proposed system will be representative elements of organized medicine -- CMS being the largest and most influential among them.

Dr. Howard notes, "Indeed, it must be obvious to both of us (Copic and CMS) that if we can't sell the concept to CMS, and other physician groups (CSOM, CAPP, ACS, DMS/AMS/CCVMS/etc.), then there probably is no reason to attempt to convince CBA/DBA, CTLA, various PIRGs, etc. (or the Legislature, for that matter!)"



Med Fax: Medico- Legal News

by *Timothy M. Schulte, Esq. and Karen B. Best, Esq.*,
associates with the law firm
of *Montgomery Little & McGrew, P.C.*

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Removing children of divorce from the state: Can't leave with 'em; can't leave without 'em.

Non-custodial parents are enjoying greater and more liberal parenting time with their children. Because of the trend toward maintaining close contact with both parents, removal of the children from the state by one parent has become an increasingly critical and difficult question. Will the Court permit the physical custodial parent or primary residential custodian (PRC) (which just means the children's legal address is with that parent) to move to another state with the children when doing so would diminish the parenting time rights of the parent remaining in Colorado? The answer depends upon the peculiar facts and merits of each case, the previous custody order, and in particular, whether the previous orders forbid removal. When the system is working correctly, the best interests of the child are paramount to the (sometimes selfish) desires of the parents.

Since long before the Uniform Dissolution of Marriage Act (UDMA) was adopted in Colorado, Courts have grappled with this question. Courts always want to know why the parent wants to move away. Historically, parents wishing to leave for a better job (more income and the promise of a more affluent lifestyle), or to be closer to stable family structures, stood the best chance of winning the right to move with the children. Unless there are issues of addiction or abuse, simply wanting to get away from the former spouse, or wanting to start a new life elsewhere, are generally not considered compelling enough reasons to deprive the other parent of his or her parenting time with the children.

Not surprisingly, some early cases stressed the importance of the non-custodial parent's parenting rights and supported the belief that denying the child the love, nurture, advice, and training of both father and mother may be more serious ill than refusing to allow the custodial parent to pursue a better lifestyle (more money) elsewhere.

Other early cases use a balancing test which seemed to discourage removal. The parent wishing to move had to show that taking the children to another state would be *better* for the children than staying where they were. In one case Dad requested permission to leave the state with the children. The court noted that when parents divorce the children become wards of the court – in other words, they will be protected by the court – and that the policy in this state discourages removal unless the child's well-being and future welfare would be better served by the move.

Since adopting of the UDMA in 1973, though it nowhere addresses the removal question, Courts have softened their stand on removal requests in favor of allowing them. In a 1982 case the sole custodian requested permission to move with the children. There was no previous order prohibiting it. The trial court allowed the move saying that there had been no showing in the record that the contemplated move would be detrimental to the child. It went on to state that as the custodial parent, absent restriction contained in the dissolution decree or separation agreement, the mother had broad discretion to leave the state of Colorado with the child so long as the move was in the best interests of the child.

The old test required an affirmative showing that the removal was best or better for the child. Now, the court will consider not only the best interests of the children, but also will look to the non-custodial parent to show that removing the children would be worse for them. The burden of proof has shifted to the non-custodial parent. Some courts have rationalized this position by stating that, "Placing the burden of seeking judicial relief upon the party who protests a relocation should encourage private resolution of the emotional and ideological issues both parents invariably confront in these cases." Interestingly, those courts also take the position that the custodial parent with no court-ordered restrictions on moving can do so even without first modifying the parenting time rights of the non-custodial parent.

The non-custodial parent is in a stronger position to defeat removal if the court-order – typically the Separation Agreement, Decree, or a post-decree order modifying custody or parenting time (formerly known as visitation) – contains restrictions on the custodian's ability to move. In the most frequently cited removal case, the mother had sole custody of the children but was prohibited by the dissolution decree from moving outside of a 20 mile radius without Father's consent or court order.

Next month more on sole and joint custody arrangements

For further information concerning this or any other domestic relations topics, call Timothy Schulte, Esq., or Robert Beattie, Esq., at Montgomery Little & McGrew, P.C., who concentrate their practices in the area of family law, including divorce, child custody, visitation, child support, maintenance, property division and adoptions.

CMS Med Fax

Colorado Medical Society Leadership Conference

May 18-19, 1996
Beaver Run Resort - Breckenridge

Schedule

Friday, May 17, 1996

1:00 p.m.-	2:00 p.m. ----- Finance Committee
2:00 p.m.-	5:00 p.m. ----- Board of Directors
7:00 p.m.-	9:00 p.m. ----- Dinner (by invitation)

Saturday, May 18, 1996

8:00 a.m.-	8:30 a.m. ----- Continental breakfast
8:30 a.m.-	8:40 a.m. ----- Welcome—M. Ray Painter, MD
8:40 a.m.-	9:40 a.m. ----- Conference overview - Dr. Painter and Ken Whitney
9:40 a.m.-	10:00 a.m. ----- Break
10:00 a.m.-	12:00 noon ----- Conference
12:15 p.m.-	1:15 p.m. ----- Lunch (Spouses/guests may attend)
1:30 p.m.-	3:30 p.m. ----- Conference
3:45 p.m.-	5:00 p.m. ----- Nominating Committee
6:30 p.m.-	7:00 p.m. ----- Cash bar
7:00 p.m.-	9:00 p.m. ----- Dinner - (attendees/spouses/guests)

Sunday, May 19, 1996

8:00 a.m.-	8:45 a.m. ----- Breakfast
8:45 a.m.-	10:30 a.m. ----- Conference Wrap-up

Ken Whitney will be the facilitator at the CMS Reevaluation Project in Breckenridge on May 18-19. Excelling at creating a "chemistry of commitment" in the strategic planning process, Mr. Whitney brings over twenty years of facilitation and training experience.

As president of Whitney, Jones & Dunn, he works primarily with national and state professional association board of directors to attract and sustain board and membership involvement. From 1971-1987 he was a program director for the Institute of Cultural Affairs International, a private development organization which pioneered consensus building techniques and planning technologies. He is a member of the American Society of Association Executives.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

International Meniere's Disease Research Institute

9th Annual Electrocotchleography/Otoacoustic Emissions/Intraoperative Monitoring Seminar
Summer 1996, Denver, Colorado
AMA and ASHA CEU's offered
Contact: Jane Wells or I. Kaufman Arenberg, MD
(303)778-4235

Society for Computer Applications in Radiology

Symposium in Computer Assisted Radiology
June 6-9, 1996
Denver, Colorado
(703) 716-7548

Universtiy of Colorado's CME in the Rockies

42nd Family Practice Review
June 16-22, 1996
Estes Park, Colorado
1-800-882-9153 or (303) 372-9050

Institute for Natural Resources

Beyond Prozac: Depression, Stress, Diet and Drugs
June 20, 1996
Billings, MT
1-800-937-6878 or (510) 652-1859

American Medical Association

Organized Medical Staff Section(AMA-OMSS)
27th Annual Meeting
June 20-24, 1996

Chicago, Illinois

(800) 262-3211

Colorado Society of Osteopathic Medicine

Annual Meeting
June 21-23, 1996
Manor Vail Lodge, Vail, Colorado
18 hours AOA category 1-A CME credits, FP and Physician Assistants credits
Contact: Patricia Ellis (303) 332-1752

Institute for Natural Resources

Beyond Prozac: Depression, Stress, Diet and Drugs
July 10, 1996
Cheyenne, Wyoming
July 11, 1996
Colorado Springs, Colorado
1-800-937-6878 or (510) 652-1859

Universtiy of Colorado's CME in the Rockies

32 Internal Medicine Program
July 14-19, 1996
Estes Park, Colorado
1-800-882-9153 or (303) 372-9050

Universtiy of Colorado's CME in the Rockies

23rd Renal Disease and Electrolyte Disorders
July 22-26, 1996
Aspen, Colorado
1-800-882-9153 or (303) 372-9050

Colorado Otolaryngology and Maxillofacial Society

The Cutting Edge of Otolaryngology
July 24-25, 1996

Doubletree Antlers Hotel
Colorado Springs, Colorado
Contact: Bob Conlon, MD or Debbie Brown
(970) 484-8686

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
June 27-28, 1996
Englewood, Colorado
(303) 397-7876

American Psychiatric Association

Dynamic Psychotherapy in the New Era
July 29-August 2, 1996
Aspen, Colorado
18 Hours CME Credit, Category 1

Contact: Maria Gorrick (202) 682-6145

American College of Cardiology

Echocardiographic Symposium on 2-D and Doppler Echocardiography
July 29-August 1, 1996
Vail, Colorado
23 Category 1 AMA
(800) 253-4636





Sandra L. Maloney
Executive Director
Colorado Medical Society



The number of specialists who find themselves terminated from managed care plans is predicted to escalate. CMS has been receiving inquiries from specialists who are interested in some retraining in the delivery of primary medical care. An example is a physician who is board certified in both pediatric allergy and general pediatrics. He is currently practicing in pediatric allergy, but wishes to return to general pediatrics. Recognizing that the return to general pediatrics could not occur without proper retraining, he sought help. Like many of you who may have this same need, he did not know where to turn.

There is an organization right here in Colorado who can provide this type of assistance. The Colorado Personalized Education for Physicians (CPEP) Program, a nonprofit organization, is the product of collaborative efforts undertaken by seven Colorado health care organizations. After four years of study, CPEP was incorporated in 1990. Since that time, over 130 physicians from all over the country have utilized its services.

CPEP serves physicians who may self-refer for focused educational interests as well as physicians referred as a result of a review process. In recognition of the broad range of knowledge and skills that are required for a successful medical practice, CPEP provides coordination of education activities in the general categories of: 1) medical knowledge; 2) clinical reasoning; 3) interpersonal/communication skills and; 4) patient care documentation. Scientific knowledge has been the

domain of undergraduate and graduate medical education, as well as traditional continuing medical education (CME). CPEP promotes continuous education beyond medical school and residency programs by focusing on the individual training needs and interests of the practicing physician.

How does CPEP work?

The CPEP program will:

- Under the direction of a Medical Education Director, conduct a two-day assessment focusing on the physician-participant's medical knowledge, clinical reasoning, communication skills, and patient care documentation. Assessment activities are held in Denver. A final written report is provided.
- Develop educational objectives based on the assessment findings. A focused, intensive and personalized educational program, based on those objectives, is then designed. The learning plan defines the methods for evaluating the achievement of learning objectives. To the extent possible, physicians maintain their normal clinical practice. Learning plans are designed and carried out in the physician's geographical location whenever possible with time frames varying from three to eighteen months. Learning plans are based on individual needs and preferred learning styles.
- Assist the participant in arranging activities necessary to achieve the educational program objectives and monitor participant progress.

"Retraining physician specialists may prove to be one means of augmenting the thin ranks of primary care, while providing specialists with an opportunity to continue in productive clinical practice."

(Continued on following page)

EXECUTIVE DIRECTOR'S UPDATE

(Continued)

As necessary, changes in the learning plan will be facilitated.

- The Medical Education Director conducts follow-up evaluations to document fulfillment of educational objectives and report findings to the participant or to relevant organizations, when appropriate. Evaluations are usually conducted every six months, after which a report is written.

What are the benefits of CPEP?

CPEP provides:

- An external, non-biased assessment of physician skills in a variety of practice settings.
- An objective summary of participant strengths and weaknesses by experts in the physician's specialty field.

- A constructive alternative to sanctions by hospitals or other organizations.
- Assistance in redirecting the patterns or scope of practice.
- An atmosphere of professional collaboration and encouragement to address specific areas of educational need and to promote change and growth.

Who uses CPEP?

CPEP works with physicians who are:

- Seeking to update their clinical knowledge and technical skills;
- Planning a career transition or returning to clinical practice after an absence;
- Recovering from a disabling accident or illness and;
- Seeking assistance to address state licensing board, PRO, or hospital patient care concerns.

All services provided by CPEP

are kept strictly confidential. Remember, CPEP is not a peer review organization and does not have disciplinary authority. CPEP charges for its services, with varying fees depending on the depth of education needed. Please contact CPEP at the number listed below for further fee information.

Retraining physician specialists may prove to be one means of augmenting the thin ranks of primary care, while providing specialists with an opportunity to continue in productive clinical practice. While retraining of this sort poses special challenges for all involved, we feel that CPEP can meet those challenges. If you need this type of help, or simply would like further information, please contact Ms. Beth Korinek, Executive Director of CPEP at (303)750-7150.

YOU

THE NUMBER 1 REASON YOUR PATIENTS
WILL HAVE A MAMMOGRAM THIS YEAR.

No matter what your specialty, the American Cancer Society needs you to recommend an annual mammogram for every woman over 50. An annual mammogram is critical for early detection and intervention, yet too many women are not hearing this message.

Take the first step. Call 1-800-ACS-2345 for information that can help you make an impact.

give the word.

MAMMOGRAM
EVERY YEAR AFTER 50



A Public Service of
This Publication





Vertical Integration or *Virtual Integration?*

For years we have been promised the benefits of **vertical integration** - bringing the entire healthcare system into one corporate structure. Physicians, hospitals, and even insurance products are being joined into a single entity.

Michael J. Manley, "The Promise of Integrated Health Care: Simple Strategies for Transforming Organizations," Medical Group Management Journal p. 26, January/February, 1996.

Lately, however, there has been much talk of virtual integration, in which providers link up "through information systems and contractual relationships rather than common ownership and control."

"Virtual Healthcare: Linking Firms to Form All-Star Teams," Modern Healthcare, p. 42, March 18, 1996.

There are pluses and minuses in both these approaches.

Robert C. Bohlman, "Watch for Bumpy on Road to Consolidation/Integration." American Medical News, p. 15, August 28, 1995.

James C. Robinson and Lawrence P. Casalino, "Vertical Integration and Organizational Networks in Health Care," Health Affairs, p. 8, Spring, 1996.

As a matter of fact, there is almost no evidence that costs become lower or quality becomes higher with any type of integration.

David Dranove, Amy Durkac, and Mark Shanley, "Perspective: Are Multihospital Systems More Efficient?" Health Affairs, p. 100, Spring, 1996.

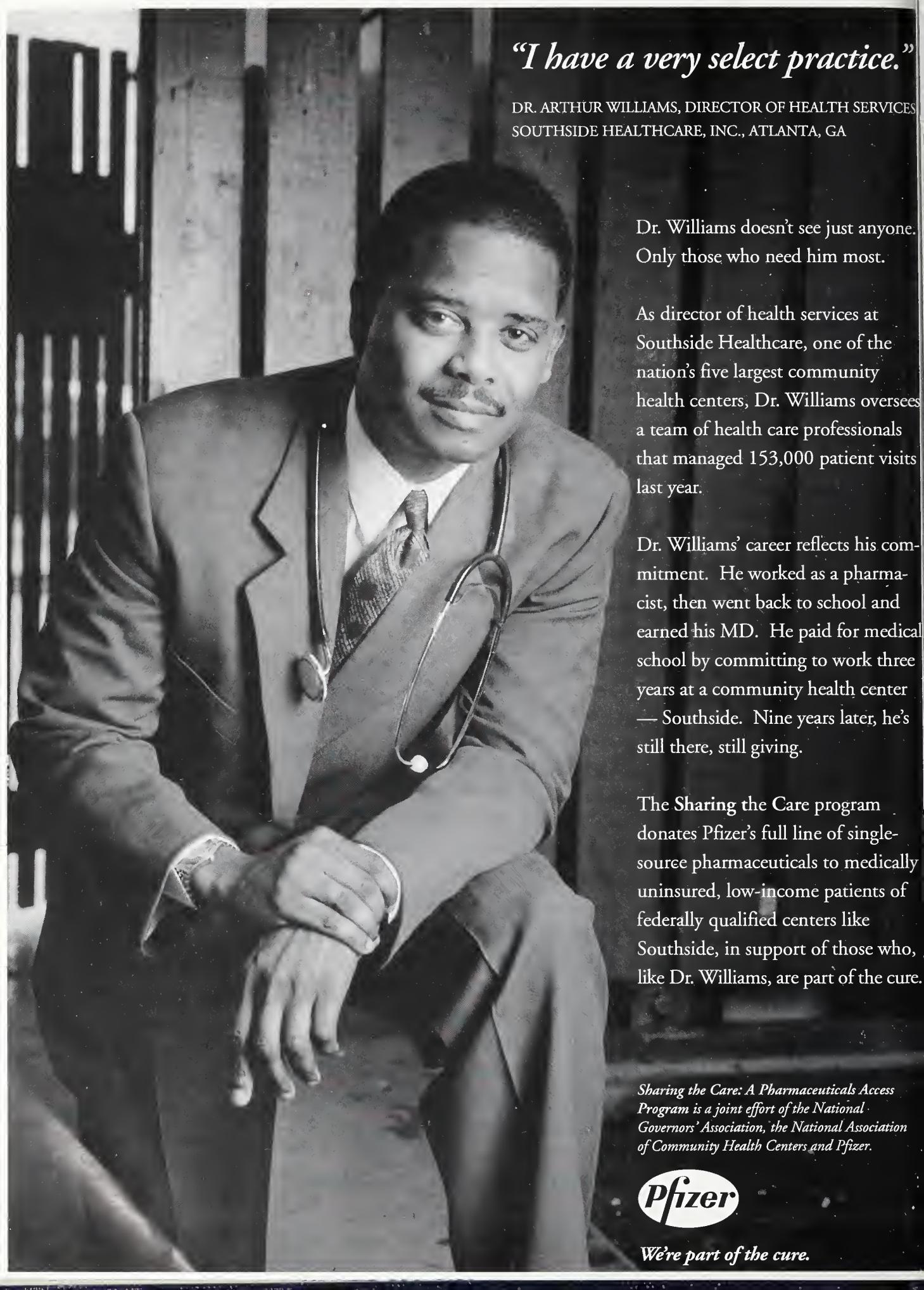
Questions should and are being raised about who benefits from mergers and acquisitions that result in greater levels of integration and aggregation.

Jeff C. Goldsmith, "Burning the Seed Corn" Healthcare Forum Journal, p. 19, March/April, 1996.

Jerome P. Kassirer, "Mergers and Acquisitions - Who Benefits? Who Loses?" The New England Journal of Medicine, p. 722, March 14, 1996.

These are interesting articles that might change your mind about the benefits of larger, more inclusive organizations. If you cannot obtain copies of these articles through your local medical library, please call Lorraine Heth at the Colorado Medical Society for reprints at (303) 779-5455 or 1-800-654-5653, Extension 2409.

Leigh Truitt, MD



"I have a very select practice."

DR. ARTHUR WILLIAMS, DIRECTOR OF HEALTH SERVICES
SOUTHSIDE HEALTHCARE, INC., ATLANTA, GA

Dr. Williams doesn't see just anyone.
Only those who need him most.

As director of health services at Southside Healthcare, one of the nation's five largest community health centers, Dr. Williams oversees a team of health care professionals that managed 153,000 patient visits last year.

Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



We're part of the cure.



by Richard Allen, MD, Chairman
Council on Legislation

We're finally in the home stretch! The Legislature is scheduled to adjourn on May 8; however, local press reports have kept the pressure on to lower health care costs. Reduced costs are certainly important, but experience in other states suggests that as the managed care market matures, costs will even out and the emphasis will shift to quality. As physicians we must continue to espouse the ethical principles of beneficence and patient autonomy. The Legislature is also beginning to understand and react to those principles thanks to the efforts of the CMS leadership, Government Relations staff and CMS lobbyists.

Active lobbying efforts have been focused on five bills: **HB 1216** the Gag bill; **HB 1232** Regarding Mandatory Renewal of Health Benefit Plans; **SB 93** Peer Health Assistance Programs; **HB 1185** Death with Dignity and; **SB 148** Access to Peer Review Records. The "Gag" bill, which prevents managed care organizations from retaliating against providers who openly communicate with patients about a health plan, is awaiting the Governor's signature. This bill has received some national attention, with at least four or five states introducing and or passing similar legislation. HB 1232 passed. SB 93 and HB 1185 (were bills that CMS opposed) were killed in committee. SB 148 would have destroyed the peer review process, but it too was killed in committee.

Bills that CMS opposed that were postponed indefinitely include: **SB 41** regarding a fee-limiting subfund for licensure fees; **SB 79**

mandating changes in prescription writing; **SB 154** concerning unconventional methods of treatment and; **HB 1162** regarding fees for medical records.

CMS also opposes two bills awaiting final action. They are **SB 47**, which would place a majority of Medicaid patients into managed care, and **SB 92**, which would expand the scope of practice for optometrists.

A major defeat came when **HB 1073**, the Rural Health bill, was killed in the House Appropriations Committee. The bill would have established a state run loan repayment program to encourage young physicians to practice in rural Colorado. Rural health continues to be a priority for CMS. In an unprecedented step during the Interim Meeting of the House of Delegates, the CMS Board of Directors unveiled a plan to sponsor the initial start-up costs of the program. By administering the plan to recruit and retain rural physicians through loan repayment, CMS will reemphasize its commitment to rural health.

The other legislative setback came when **HB 1191** was killed. This bill would have set up a community health care initiative to provide partnerships between private and public entities to finance care for uninsured Coloradans. The need to provide and fund care (particularly preventive care) for uninsured Coloradans is imperative. Undoubtedly this issue will be revisited.

The need to educate the public on the practical workings of managed care is also an issue that needs to be addressed by physicians.

"As physicians we must continue to espouse the ethical principles of beneficence and patient autonomy."

Coalitions between physicians and patients, like the recent one between the AMA and the AARP which outlined a set of rights for managed care enrollees, are the stepping stones by which our legislative efforts can reflect the principles of our profession. On the local front, meetings with the Insurance Commissioner's office, businesses and the insurance community have expressed interest in ensuring such protections. As in the AMA/AARP coalition report, reasonable choice of providers, access to specialty care when needed, knowledge of how a plan pays physicians and others and the right to appeal coverage decisions must be guidelines for upcoming action.

The potential conflict between the traditional values of patient benefit and autonomy, and the ascendant values of economic self-interest and efficiency are at the center of clinical decision-making and new health care financing schemes. The ethical principles of medicine which influenced this year's legislation, must also play a role in assuaging potential, future conflicts.



SAMPLE

PHYSICIAN PROFILE

Physician Profiles are produced through a joint project of Gadrian Corporation, the Colorado Medical Society, and Copic Insurance Company. This profile is made available to you as a courtesy by your physician. For more information about how the report was prepared, see the back of this form.

JOHN DOE

5680 GREENWOOD PLAZA BLVD
STE 260
ENGLEWOOD, CO 80111-
(303) 930-2600

Med School: GEORGETOWN UNIV SCHOOL OF MED
Degree: MD - 05/01/1972

Graduate Medical Education:
R ST LUKES HOSPITAL
Specialty: PROCTOLOGY

Specialty Board Certification:
AMERICAN BOARD OF UROLOGY

Practicing Medicine Since : 1972

Hospital Affiliations:
HEALTHONE HOSPITALS
SWEDISH MEDICAL CENTER-ENGLEWOOD

Languages Spoken at Office : ENGLISH

Does Physician take Medicare : Y Medicaid : Y

Has the state licensing board taken any action against this physician's license?

According to the records of the State Board of Medical Examiners (checked 02/01/96), this physician holds a current, unrestricted Colorado medical license. There is no history of any action against this physician's license during the five-year time period covered by our search.

JOHN DOE



by **Bill Pierson, Director of Member Services**
Colorado Medical Society

Physician Profiles: An idea whose time has come!

The responses have been everything from "So What?" to "Oh, I see" when someone has mentioned the "Physician Profile Project (3P)" or the "Physician-Specific Data" resolution.

Each of approximately 4,000 physicians in Colorado received a "Physician Profile", typical of the John Doe type reproduced here. Yes, it is limited, in light of what the consuming public has been clamoring for, BUT it is a start.

The physician reaction has been good, especially judging by the number of requests for changes in the profile data (1,200 requests). And that is what prompts this article — THERE HAVE TO BE RULES!

Here are the rules:

1. After you entered your request for changes to the profile that was sent you, you should have received a corrected profile in the mail. You are now free to use this to copy and distribute to your patients.
A. Again, we recommend that you copy this profile, just as it came to you on the Gadrian Corporation letterhead, so that the patient can see the profile was done by a third-party objective reviewer. CMS or Gadrian will not be distributing the profiles; YOU will. You're the only one from whom the patient can obtain your profile.
2. What you received in this profile, like the one reproduced here, is the extent of information that Gadrian can incorporate in this piece. There won't be many changes in the future, except for some updating to keep the profile current. PHYSICIANS REQUESTING NEW PROFILES OR CHANGES TO EXISTING PROFILES (within the guidelines/rules set down here) should submit to Ellen Stein at CMS, (303) 930-0414. These changes will be logged and the request sent on to Gadrian. Gadrian will be doing a new profile run monthly.

3. The profiles will be "proofed" for spelling and accuracy according to the requests, as best we can.
 - A.** Physicians must be aware that these profiles ARE NOT MEANT TO NOR WILL THEY EVER SERVE AS A CURRICULUM VITAE. The contents are limited to those subjects which can be verified by the Gadrian system with the primary source.
 - B.** Only the basic (or primary) specialty will be listed, as it is listed by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA).
 - C.** The physician's PRIMARY address will be listed, because many physicians have multiple addresses. If the physician wants patients to know of other practice addresses, the physician can include these in an addendum to the profile sheet.
 - D.** Gadrian will print on the profile whichever title is reported on the application.
 - E.** Additional training will not be added to the profile. Such items can also be added, in a cover letter to the profile, by the physician.

"—THERE HAVE TO BE RULES!"

- F.** Board eligibility will not be added to the profile. The ABMS recommends that organizations not recognize this status.
- G.** Any discrepancy in specialty (i.e., gastroenterology vs. geriatrics) will be corrected as identified.
- H.** Gadrian has already made the appropriate changes in the system to correct the "date of practice" problem. It has been noted by a number of physicians that their medical school name was improperly listed in the profile. It was found that some schools and hospitals had changed their name in recent years. To correct this, Gadrian lists the education at the original school or hospital, with a "c/o" designation indicating there is a new name. Regarding the University of Colorado Health Sciences Center, Denver, Colorado, this may be a space issue that cannot be corrected except with an abbreviation of the name.
- I.** The profile does not talk about Medicare assignment -- it merely reflects whether you see Medicare patients.

There you have the rules to date. This is a long-term project, so there will be future changes.



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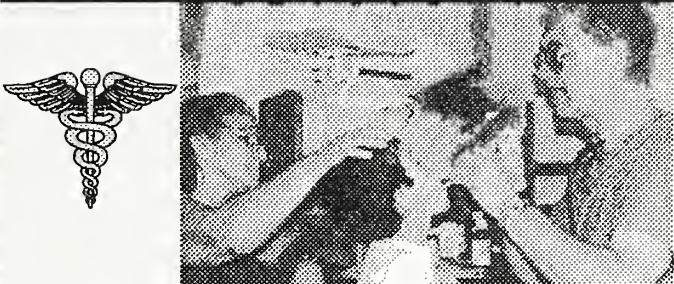
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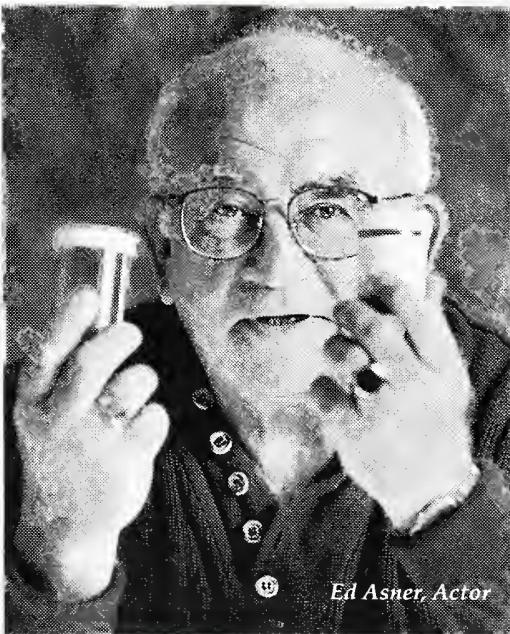


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Ed Asner, Actor

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John Lightburn, MD
Historian
Colorado Medical Society

The Typhoid Epidemic of 1879

The decade of the 1870s was a time of rapid and chaotic growth for Denver. With the influx of thousands of fortune seekers on their way to the gold and silver fields in the mountains to the west, Denver grew from a village of 4,000 in 1870 to a city of 20,000 by 1879. A bewildered city council was unprepared to comprehend or solve the problems of uncontrolled growth.

As the city grew, its state of sanitation declined. Population growth produced an increase in the number of wells, privies and cesspools. There must have been over 2,000 privies filled to overflowing (a historical fact that is not shown in the typical western movie). Moreover, wells for drinking water were dug near those overburdened privy vaults.

Venture capitalists from England decided to address the sanitation problem by investing \$100,000 for a modern water system. Thus, the Denver City Water Company was established headed by Colonel James Archer, recently of Her Majesty's army. Faced with the daunting jobs of supplying potable water to the city and producing a profit for investors, Col. Archer was ill prepared for the unexpected increase in demand for water.

As Col. Archers waded through the Denver City Water Company problems, a fledgling Denver Medical Association (DMA) was also taking steps to address the sanitation problem. The prime mover in this effort was Dr. Frederick J. Bancroft. Simply a huge man (six feet, four inches tall, weighing over 300

pounds), Dr. Bancroft was famous for his size, diagnostic and surgical skills and his infectious humor. He was a founder and charter member of the Denver Medical Society, president of the state historical society for 17 years, president of the Stat Board of Health and president of the school board. On March 12, 1878 Dr. Bancroft presented a paper to the DMA describing Denver as a very dirty city. The paper detailed the fact that there was no systematic garbage collection, no sewer system, overflowing privy vaults and an inadequate water system. "Whoever will take an early morning drive through the town will not fail to see a dozen or more dead rats, and perhaps several defunct cats. These and other refuse are soon ground by passing vehicles into impalpable dust which.... is taken into the mouth, nostrils and lungs"

In response to Dr. Bancroft's paper, the association appointed a hygiene committee to investigate the problem and report back. The committee responded with a series of recommendations to the city council. The proposals were published as an open letter to the Rocky Mountain News to provoke public pressure on the reluctant council. The council procrastinated until May 22, 1878 when Cherry Creek flooded and wreaked havoc on the city. Recovering from that flood drained the city's resources (no FEMA in those days). In January, 1879, the undeterred council passed the 1879 budget, allotting only \$1,000 for health purposes.

Editorials in the Rocky Mountain News predicted that the city was

"A young man who is too lazy to be a mechanic, lacks brains to be a lawyer goes into being a doctor."

—Colonel James Archer
President of the Denver City Water
Company, in a letter to the
Rocky Mountain News
on December 11, 1879.

headed for disaster if the sanitary conditions did not improve. The medical association again described the urgent need for a sewer system and also began to complain about the water system.

In the meantime, a traveler came through town carrying what is now called Salmonella Typhi, a very sneaky bug. Maybe he camped on the banks of the Platte river on his way to Fairplay. Wherever the infection originated, physicians began to notice increasing numbers of patients with typhoid fever. Alarmed they met and passed resolutions that the water company was delivering polluted water. They urged the city fathers to force the water company to live up to the terms of its contract with the city. The water company,

however, was producing twice as much water as it was designed to deliver, using water from practically any source.

As the summer passed into fall, the number of patients with typhoid fever rose to over 600, and the debate between the medical community and the water company intensified.. In a letter to the Rocky Mountain News in response to a storm of criticism, Mr. Richard Holme, cashier of the Denver City Water Company, wrote: "The water now furnished by this company is about as good as Denver can ever hope to have, and we should all try and be content". Holme then charged that the DMA had no proof of its allegations, nor were members of the association qualified to analyze the water. Col. Archer contended that doctors were blaming the water company because of their ongoing failures to experimentally treat patients. "Experiments," he added, "(that) have sent so many to fill our cemetaries". Concluding his verbal assault on the DMA and the profession of medicine Col. Archer scoffed, "A young man who is too lazy to be a mechanic, lacks brains to be a lawyer goes into being a doctor".

The epidemic eventually subsided as the number of typhoid case declined. As a result of the epidemic, the city council finally agreed to build a sewer system as Dr. Bancroft and his colleagues had recommended two years earlier. The sewer system was eventually completed three years later. Col. Archer invested more money to improve the water system, but it was many years before a truly adequate filtration and chlorination system was built.

Typhoid fever continued to be a subject of clinical interest, appearing in the *Denver Medical Times*, *Colorado Medicine* and numerous other papers. These articles give an interesting insight into the medical practice of that day and excerpts from three articles follow.

Typical of that day was the approach described by A. B. Atwood, M.D. in his article in The *Denver Medical Times*. He wrote "(If the patient is fairly strong, give aconitine, gr. 1/134 ...each every hour for twelve hours; also one of calomel every hour for four doses, followed by a saline to flush out the bowels. Zinc sulpho-carbonate is given to saturation if there is diarrhea. . . I withhold all nourishment for 48 hours". Dr. Atwood used "sponges" and baths to control fever.

Almost all the papers of that day encouraged the use calomel, citrate of magnesia and enemata to keep the bowels "cleaned out".

A novel approach was described by Dr. L. T. Durbin, M.D. of Denver in a 1909 issue of the *Denver Medical Times*. As a preface, he offered his "opinion that this disease...is caused primarily by the undoubted influence of rapid and sudden changes in atmospheric temperature" noting that the disease occurred mostly in the changing

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Colorado Medical Society

seasons. "So we have a change in the dietary not adjusted to changes in atmospheric conditionsproceeding to the resulting irritations and erosions of the internal lining membranes through which the so-called typhoid bacilli enter the glandular system and infect the entire body. Whether or not we adhere to the germ theory as to the origin of the disease, we must admit that all the recognized germs may be found latent in healthy bodies". Dr. Durbin then gave a lengthy account of his theory that infections occur only if the protective membranes are compromised and that Nature will cure all "broken tissue if the tissues are cleansed.... all debris and germs are removed and kept removed....". With this explanation of the disease process, he presented the following procedure: "Give a cleansing dose of calomel, say 8 gr. with 1 gr. of soda bicarb. Give the patient no nourishment whatever for one week, if possible--nothing but distilled watercleanse the rectum and colon with soap suds enemata; then follow

with irrigation of the entire colon with sterilized water, from 60 to 90 degrees F. with Kemps tube, once each day, using from two to four gallons....". Not till after the patient's temperature had returned to normal for three days did he stop the irrigations and allow food to be given. One might consider this as an anal approach to medical care.

A less drastic approach was described in the November, 1905 issue of the *Denver Medical Times*, "Treatment of Typhoid Fever" by C. B. Van Zant, MD of Denver. Dr. Van Zant wrote, "I believe it may be put down as axiom, that the longer one's experience is with this disease, the less will his faith be in any line of specific medication. Intestinal antisepsis elimination by purgatives or colonic salt injections, antipyretic drugs, and so forth, have all had their advocates and, in my judgment, their day. If past experience in the treatment of typhoid fever has borne any real fruitage, it may be summed up in the old phrase, "masterly inactivity," in the use of

drugs. More and more it has come to be felt in the profession that typhoid fever is peculiarly a disease in which trained nursing is the *sine qua non*; and in which the faithful care of the sufferer rather than a harsh assault on the disorder itself turns the scale toward recovery. . . . In this disease it is preeminently true that a good nurse without a doctor is better than the best doctor without a good nurse". Dr. Van Zant continues for eleven more paragraphs to describe "masterly inactivity". We find his message about good patient care sometimes lost in today's managed care environment.

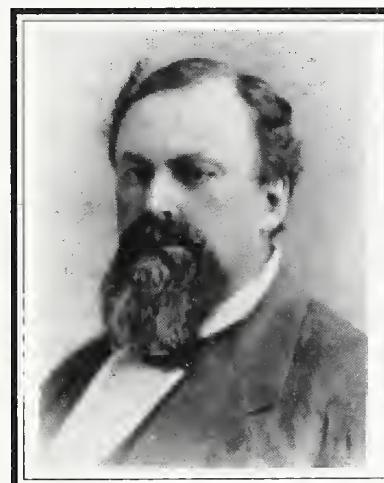
Author's note:

I am indebted to Mary DeMund of the Denver Medical Library, a wonderful medical history resource. For this article I have also relied heavily on *Public Health in Denver 1859 to 1900* by Katherine Llewellyn Hill, a Masters Thesis while a graduate student at the University of Denver.

Truly a giant of a man

* In the Colorado Medical Society Centennial celebration of 1971, the late Harvey Sethman (first Executive Director of CMS) described Dr. Bancroft as "simply huge, six-feet-four and varying between 270 and 300-plus pounds, every pound of him famous for his infectious humor and continual joshing - famous also for his skill in diagnosis and surgery. He was as big professionally as he was physically, and his friends were legion. He even made a lifelong friend of truculent, warlike, Chief Colorow, with whom he exchanged practical jokes and whose gifts to the doctor are now prized by museums.

Dr. Bancroft arrived in Denver by stage in 1866, and he became a founder of the Denver and Colorado Medical Societies, the State Historical Society (President 17 years), the State Board of Health (President two years), Saint Luke's Hospital, Denver Univer-



Frederick J. Bancroft, MD*
1834 - 1903
11th CMS President

sity Medical School, the Denver School Board (President many years) and he was usually either chief surgeon or local surgeon for every railroad serving Denver.

He'd had wide experience as a Union Army Surgeon, and he was the only Union doctor permitted (and reluctantly since Bancroft was a

Connecticut Republican) to treat Confederate President Jefferson Davis' painful facial disease while the latter was a Union prisoner.

Dr. Bancroft was both a gourmet and a gourmand. A friend of similar tastes took him to dinner at the just-opened Brown Palace Hotel. Each consumed two dozen raw oysters as an appetizer, then a large roast turkey was served as the entree. Dr. Bancroft looked mournfully at his host's choice and said 'A turkey is such an awkward bird, a little too much for one and not enough for two.' The host immediately ordered a supplementary roast chicken!

His buggy was built with extra heavy springs on the driver's side - he'd broken the springs of others, including that of his friend Dr. Jesse Hawes of Greeley; so when Dr. Hawes again called him in consultation he met Dr. Bancroft at the railway station with a hay wagon, much to the amusement of all concerned, including many bystanders."

Rural Health Resurrected

Jack Berry, MD, Chairman
Colorado Medical Society
Rural Health Care Task Force



"The hope is to have the first loan repayment funds available for distribution by June of 1997."

On the morning of April 9, the House Appropriations Committee killed the Rural Health bill. By the afternoon of that same day, plans were in place to resurrect the rural health program. In a bold step by a motion of the CMS Board of Directors and a subsequent resolution of the CMS House of Delegates, the Colorado Medical Society will develop and implement the project.

The reinvigorated program will now be known as the **Colorado Rural Health Professionals Incentive Program (CRHPIP)**. It will function as a loan repayment project to help recruit physicians to rural Colorado.

Eligible participants must be physicians in their final year of residency training who have outstanding federally qualified student loans, and who agree to practice in a rural area for a period of not less than three years are eligible. In the Rural Health bill physicians, physician assistants and advanced prac-

tice nurses were eligible. Since this is now a CMS project, funding will focus specifically on physicians for the time being.

CMS will finance the beginning stages of the program. As the project matures monies will have to come from other sources. Per **RES-25-P (Interim Meeting '96)**, CMS has been authorized to spend up to \$20,000 to sponsor and administer a program for loan repayment, recruitment and retention of rural physicians. Expenditures beyond that amount will require that a written plan (including fiscal impact statement) be submitted to the CMS Board of Directors and the House of Delegates for approval. Introductory financing will go toward program start-up costs. The funds for the actual loan repayments will have to be raised through: 1) private grants, donations and contributions and; 2) the establishment of a community-match program.

Similar to the legislation, a Colorado Rural Health Professionals Incentive Committee will be created to develop recommendations on implementing the program. It will be composed of rural physicians, experts in the field of rural health care or recipients of rural health care. The committee will work within CMS, as do other councils and committees, with oversight from the Board of Directors and House of Delegates. The existing CMS Rural Health Task Force will play a primary role in the beginning stages of program and committee development. Start-up staffing will come from the CMS Department of Health Care Policy.

There are numerous pros and cons to CMS' attempt to administer the program. Rural health has been a long-standing priority for CMS. Originally the legislative route was pursued because it was thought that the State had an obligation to contribute to the funding of solutions to the problems of access to health care in rural Colorado. The legislation had an \$80,000 fiscal note to cover the start-up administrative costs for this program. The bill's demise signalled:

- the loss of initial funding and;
- the loss of potential State interest in the success of the program.

By making the CRHPIP a CMS project:

- certain time-consuming governmental procedures have been avoided;
- complete control over program design and implementation has been gained and;
- an earlier start-up date is now more feasible.

CMS staff is in the process of developing a project description and budget (based on the legislation) which will outline the steps for initial program start-up. The project description will be completed by early May. The hope is to have the first loan repayment funds available for distribution by June of 1997. If you have any questions about the CRHPIP please call the CMS Department of Health Care Policy at (303) 779-5455 or 1-800-654-5653.

Examining the Electronic Medical Record

Advances in Medical Informatics

by Chet P. Seward
CMS Communications

A case study

The future looks grim for the paper medical record. While the death bell has not tolled for the traditional manila folder, the need for enhanced communication, continual quality improvement and integrated continuums of care has spawned a successor. The logical step for many practitioners today is to go "electronic". Electronic medical records (EMR) have numerous advantages over paper records. The EMR improves legibility, facilitates record retrieval, increases communication between providers and reduces redundancy. The EMR is also rarely lost, misplaced or misfiled.

Dr. Robert D. McCartney, of GeriMed of America in Denver, Co., agreed that electronic medical records are the wave of the future. He decided to electronically convert the long-term care practice three years ago. Today he admits that it would be difficult to retrain himself in the ways of "paper". With the stroke of a key he can now track any number of patient records which include past histories, patient interviews, nurse/physician notes, vital signs, allergies, laboratory results, medication lists and interactions, and telephone messages.

It took a concerted effort by everyone at GeriMed of America to implement the EMR. All the system software and hardware had to be put in place first, and then a day was chosen to begin using the EMR. Old paper records were preserved, but any new information was typed into the computer after that date.

It was initially tedious to input physician/nurse notes, lab results

and phone messages. However, as the staff became accustomed to the system, the process became faster. The transition was accelerated by dictated physician notes, on-line connections with laboratories and nursing homes and transcription services by hospitals. Now the team of three physicians, a nurse practitioner, two triage nurses, secretarial and administrative support and a medical transcriptionist has over 1,300 patients in the system serving over 30 nursing homes in the Denver metro area. The medical record is housed at the clinic, using *Physicians' Microsystems' Practice Partners* software and ten work stations in examining rooms and offices linked through a Novell network.

Dr. McCartney is quick to note the electronic security of the system. An electronic signature is required every time someone accesses a record. Files are consistently checked and backed up so that inaccuracies are amended and record integrity is preserved. It made sense for both security and practical reasons to switch to the electronic system after Dr. McCartney found that 15% of his paper medical records were lost or misplaced on an average day.

The logical step for many practitioners today is to go "electronic".



Dr. McCartney and wife Bonnie review a patient record on an exam room terminal.

(Continued next page)

be difficult. Ensuring patients of confidentiality can also generate stress.

The positive aspects of the EMR seem endless. "It takes five minutes to learn how to easily move through the self explanatory record," says Bonnie McCartney, BSN. Long nights spent reviewing or dictating over backlogged charts may be a thing of the past. Pharmacists can log on to verify prescriptions. The medication interaction and allergy modules alert physicians of possible prescription complications before they occur. Manpower and labor expenses are greatly reduced. (The system at Dr. McCartney's office paid for itself over the span of one year by saving the money that would have been spent on a \$7 per hour file clerk.) A billing module can be integrated to generate practically real time bills that are correctly

coded. Optical character recognition programs can scan old records which can be put on CD-rom, thereby freeing up storage space. The system can also serve as a utilization review and as a source for continuing medical education.

Perhaps the most exciting feature of the EMR is its capacity to continually improve quality standards. Dr. McCartney recalls one occasion when he questioned why more cases of colon cancer were not being found. A system-wide query on low levels of iron in blood was done, and a list of patients who met those parameters was printed. From that list, Dr. McCartney was able to electronically cross check each patient's files to see if they had been tested for occult blood. Yet another list was then generated that was used to contact nursing homes to check patients for symptoms. From this

process – which was accomplished in a manner of minutes – a case of colon cancer was discovered and treatment began immediately. **Using the old paper medical record, such a search would have been impossible.**

In order to create the seamless care that is called for today, health care providers must work to become more of a team. The EMR has the potential to become a vital element in that team because it can integrate communication and information systems. Dr. McCartney contends that if health care can change from a mostly individualized cerebral process, in which only the doctor knows the specifics of a case, to a shared continuum of care using things like the EMR, then the whole team can benefit and quality can increase.

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Doctor, does this logo look familiar?

Many Colorado physicians still do not know about the State CPR Directive Program. Despite the fact that they should be getting the information from their physicians, patients and medical office personnel call the Colorado Medical Society daily with questions about orders to withhold CPR. Following is an update on how the State CPR Directive Program works:

The purpose of the Colorado CPR Directive was to create a statewide, standardized form which is easily identifiable by emergency medical personnel and other health care providers. Other do not resuscitate forms are available. However, emergency health care providers have been specifically trained to recognize the State approved CPR Directive and respond appropriately to patients' wishes.

State approved CPR Directive forms are only available to patients through their health care providers (physicians, nursing homes, hospitals and other licensed or certified health care facilities). The purpose is to ensure a dialogue between the patient and health care provider regarding how a CPR Directive relates to the patient's individual health circumstances.

Physicians and other health care providers order the CPR Directives from CMS. (See order form on next page) The Directives are \$.50 each and come in two formats: 1) Patient Directives - for use by those persons who are capable of making their own decisions regarding CPR, and 2) Authorized Agent forms - for use by an agent, chosen to make health

care decisions for someone who lacks decisional capacity to make such decisions for themselves. This includes the parent or guardian of a minor child provided that a previous do not resuscitate order has been issued by a physician. (Verification of authorized agent status may be in the form of a proxy or reflected in a Medical Durable Power of Attorney.) Each form is available in both English and Spanish. With each form ordered, you will also receive an order form for a CPR bracelet or necklace. Each patient completing a CPR Directive, should also receive this order form. Patients desiring a CPR bracelet or necklace will send the pink copy of their Directive, along with this order form, to Award and Sign Connection, Ltd., the

"State approved CPR Directive forms are only available to patients through their health care providers. . ."

vendor making this jewelry.

The Directives are three-part forms. The **top copy is the original** and should be kept by the patient in a safe but easily observable place, or carried if no bracelet or necklace is worn. It is a good idea to advise the patient to inform family members of the CPR Directive and its location as well as to notify the local EMS provider agency of the Directive. The **second copy (yellow)** is to be kept by the physician in the patient's individual medical record. The **last copy (pink)** of the CPR Directive

form is to be mailed by the patient with an order form for the necklace or bracelet.

A CPR Directive can be revoked only by the subject patient or by his or her authorized agent by destroying the original copy and the necklace or bracelet (if purchased) or by stating that revocation is desired. The physician should be notified of this decision so that the yellow copy can be removed from the patient's medical record.

Patients sometimes get confused about the differences between Living Wills, Medical Durable Powers of Attorney and CPR Directives. A brochure entitled **Your Right To Make Health Care Decisions**, developed by the Advance Directives Coalition, is available through the Colorado Hospital Association (303-758-1630). Multiple copies can be ordered from Hospital Shared Services of Colorado (303-455-1420). If you have questions about the CPR Directives, please call CMS at 303-779-5455 or 1-800-654-5653 for information.

An order form for CPR Supplies and Information appears on the reverse of this page. Have your staff copy it and use it!

Order Form for Supplies and Information Regarding Colorado Patient Directives

Ship to: _____

ATTN: _____

Address: _____

City/Zip: _____

Type of Facility: _____ Telephone () _____

Quantity	Description	Unit Price	TOTAL
	Ten Pack ENGLISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Ten Pack SPANISH: Five Patient Directives Five Authorized Agent Directives	\$5.00	
	Twenty-Five Pack ENGLISH: Patient Directives	\$12.50	
	Twenty-Five Pack SPANISH: Patient Directives	\$12.50	
	Twenty-Five Pack ENGLISH: Authorized Agent Directives	\$12.50	
	Twenty-Five Pack SPANISH: Authorized Agent Directives	\$12.50	
	CPR Directive Information Packet	\$1.50 (includes postage)	
Add for postage:			
If order total is			
Under \$25.00		add \$3.00	
\$25.01 to \$50.00		add \$5.00	
\$50.01 to \$100.00		add \$6.00	
\$100.01 to \$200.00		add \$7.00	
\$200.01 to \$300.00		add \$8.00	
\$300.01 to \$400.00		add \$9.00	
\$400.01 to \$500.00		add \$10.00	
TOTAL:			

- To ensure delivery, please fill out "ATTN:" section of mailing address
- All orders must be prepaid before they will be shipped
- Forms are shipped first class
- Allow 2 weeks for delivery
- Make checks payable to Colorado Medical Society
- Mail to: P. O. Box 17550, Denver, CO 80217-0550

CMS-11/95

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Recent Affiliations and Mergers (in Colorado healthcare)

Prepared by Lorraine Heth, Program Manager
Colorado Medical Society Department of Health Care Policy

Key: DP = *Denver Post*; CMC = *Colorado Managed Care Newsletter*; RMN = *Rocky Mountain News*; DBJ = *Denver Business Journal*;
WSJ = *Wall Street Journal*; C/M = *Colorado Medicine*

"Twelve nonprofit hospitals from around the state announced that they will join forces to form . . . a network that will allow them to cut costs, consolidate operations and negotiate more favorable contracts with managed health care plans."

• **Primera Healthcare, LLC**

Primera, the integrated system affiliated with Lutheran Medical Center and St. Joseph has acquired Orchard Family Practice. The primary group, located in the Tech Center, is composed of four physicians and is headed by Dr. Frank Reed, the Chief of Staff at Rose. Primera has over 70 physicians on staff.

(CMC, 4-8-96)

• **Kaiser Permanente of Colorado and St. Joseph Hospital**

Kaiser Permanente of Colorado and St. Joseph Hospital are combining their emergency rooms into a single, jointly operated service capable of handling nearly twice as many patients. The project includes new construction at the Russell Pavilion addition to St. Joe's, renovation of existing quarters and equipment. The bigger, consolidated emergency department will help ease the crunch, particularly for Kaiser, which accounts for about 75% of the more than 62,000 combined annual emergency visits, said Kaiser Permanente president Kate Paul. The combined emergency operations already are the busiest in the state, said Sister Marianna Bauder, President and Chief executive of St. Joe's.

• **Columbia-HealthONE**

Published reports in Colorado Springs indicate that even as it was participating in the formation of the new HealthCare Colorado network, Memorial Hospital executives were meeting with executives of Columbia/HCA. Columbia is seeking to expand its Colorado network outside of Denver and Memorial has been an attractive prospect. A potential roadblock to Columbia's efforts is Memorial's status as a city facility.

(CMC, 4-8-96)

J. Robert Peters, executive director of Memorial Hospital in Colorado Springs, confirmed that Columbia officials approached him recently to discuss a possible equity position in the publicly owned hospital.

(DP, 3-28-96)

Columbia-HealthONE is exploring consolidating services at its two Aurora hospitals — Aurora Presbyterian and Aurora Regional. Columbia-HealthONE has also broached the possibility of a contractual relationship with Lutheran Medical Center, confirmed Lutheran president Kay Phillips.

(DP, 3-29-96)

• **HealthCare Colorado**

Twelve nonprofit hospitals from around the state announced that they will join forces to form HealthCare Colorado, a network

that will allow them to cut costs, consolidate operations and negotiate more favorable contracts with managed healthcare plans. Among the hospitals are Denver's University Hospital, The Children's Hospital, Denver Health and Hospitals (which operates Denver General Hospital) and Boulder Community Hospital. Also agreeing to join the nonprofit network are Memorial Hospital in Colorado Springs, Parkview Episcopal Medical Center in Pueblo, San Luis Valley Regional Medical Center in Alamosa, North Colorado Medical Center in Greeley, McKee Medical Center in Loveland and several rural hospitals. Akron's Washington County Nursing Home and Clinic will sign on as well.

The alliance falls short of an outright merger or joint venture. Each hospital in the network will retain its current ownership; hospital assets won't be merged; and the institutions will continue to operate independently, hospital officials said. Network members will purchase supplies jointly, consolidate some services, contract jointly with managed health care plans and share information and expertise. The Board will formulate a business plan in the next three months outlining more specific areas of cooperation.

(DP, 3-26-96)

• Health Systems International (HSI)

HSI, headed by QualMed founder Malik Hasan, plans to consolidate a number of claims processing offices operated in Washington state, Oregon and states throughout the East Coast to Pueblo. Documents that HSI filed last week with the Securities and Exchange Commission show that the company plans to restructure twice in the second quarter. One involves California operations. The other, apparently the genesis of the Pueblo announcement,

involves centralizing certain non-California operations.

(RMN, 4-2-96)

• University Hospital

University Hospital, as part of a 16 state network, is one of three finalists for a \$2.5 billion federal contract to handle the health care for civilian military employees, including 130,000 in Colorado. The five-year contract is under the federal Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Tricare program, which provides medical services for active and retired military and their families in the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration. University Hospital in Denver is the lead provider in Colorado under a contract bid submitted by a consortium called TriWest Healthcare Alliance, which is owned by University Hospital, 11 Blue Cross plans, the University of New Mexico Hospital system and Sierra Health Systems (a for-profit health maintenance organization in Nevada). Dennis Brimhall, president of University Hospital, said he expects a final decision to be made by CHAMPUS about May 1.

(DBJ, 3/22-28-96)

• VA Medical Center - Fort Lyon

The award winning Fort Lyon Veterans Affairs Medical Center, which specializes in neuropsychiatric and extended care for veterans from six states, is the first VA hospital in the nation to start firing and demoting staff. The cuts, linked to federal budget cuts, also coincided with a long-planned reorganization of the hospital in southeastern Colorado. They come at a time when an additional 50 long-term patients and mandated 2.39 percent salary increases have created a \$1.3 million budget shortfall at Fort

Lyon. Among a staff of 581, 44 employees have been fired, 33 reassigned and 53 demoted. The resulting \$2 million annual payroll loss is expected to play havoc in the already economically depressed Arkansas Valley of Colorado, said Bent County Commissioner Ken Kester. Fort Lyon is the largest employer in the area.

(DP, 3-25-96)

• Trends

A Department of Defense health agency will relocate from Fitzsimons Army Medical Center to a new, \$12 million office building in Aurora. The Office of Civilian Health and Medical Programs for the Uniformed Services will move its 375 employees to the new building in the Aurora CentreTech office park in late 1997. The relocation is required by the closure of Fitzsimons. OCHAMPUS manages health and medical programs for eligible military personnel and their families comprising 1.2 million people in a 16 state western region that includes 240,000 Coloradans.

(DP, 4-12-96)

Published reports have confirmed that PhyCor is in negotiation to acquire an interest in the Focus Medical Group.

(CMC, 4-8-96)

by Jerome M. Buckley, MD

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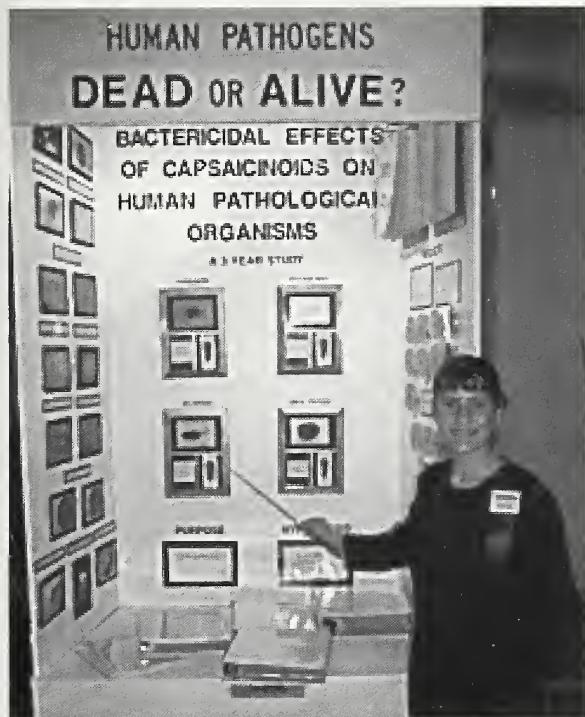
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Colorado State Science Fair Winners Receive Awards



The Forty-First Annual Colorado State Science Fair was held in April at Colorado State University in Fort Collins. Students from all over the state competed in health and behavioral sciences, botany, earth and environmental sciences, mathematics and computer science, physical science and zoology.

The Colorado Medical Society and CMS-ERF continued the tradition of supporting the science fair by providing monetary aid and honoring two students in the Health and Behavioral Sciences Category. Winners in the Senior and Junior Divisions have the opportunity to display their projects at the Annual Meeting this September in Steamboat Springs. The CMS encourages science education in a variety of contexts as a part of our advocacy of excellence in medicine and promoting the public health.

Cherise Yund (left), of Del Norte, proudly displays her award winning project at the Colorado State Science Fair. She took first place in the Senior Division of the Health and Behavioral Sciences Category for her research on human pathogens. Cherise is somewhat of a veteran when it comes to science fairs, having won awards every year since 1991. She plans on entering the medical profession in the future.

Dalyn Cook (right), a ninth grader at William J. Palmer High School in Colorado Springs, grabbed first prize in the Junior Division for her research project: "The Handsome Choice." Dalyn discovered that certain primates possess systematic handedness. Her interest in the medical field has grown substantially thanks to her experiment. Dalyn hopes to either become involved in medical research or education.

Be sure to stop by both of these interesting exhibits during the Annual Meeting. Their scientific techniques and findings may surprise you.





Healthcare Fellowship and Award

The Healthcare Forum, a nonprofit health care education and leadership organization, is supporting healthier communities by sponsoring the *Creating Healthier Communities Fellowship* and the *Healthier Communities Award*. The fellowship develops transformational leaders who create community action learning projects to increase the quality of health and life. The Award, made possible by a grant from Hoechst Marion Roussel, recognizes the joint efforts of leaders from all sectors of the community to redefine health in the spirit of collaborative problem solving. The Award is presented in three categories: small, rural and suburban; large cities and; international. Each winning program will be presented with \$10,000 at the Healthcare Forum's 1997 Healthier Communities Summit, May 3-6 in San Francisco. For more information call (415) 356-4317.

New long-term care directory

A new reference book is available for physicians working with geriatric patients. *The Consumer's Guide to Colorado Nursing Homes* is a comprehensive statewide directory of long-term care facilities outlining specific medical and therapy programs, services available, costs, regulatory compliance and key criteria for admission. This resource book is available by calling Nancy or Maria at (303) 604-1459.

CMSA donates \$20,000 to AMA-ERF



CMSA members present their AMA-ERF contributions to Richard Krugman, MD. (From l to r: Patti Brown, Dr. Krugman, Jo Netz and Nancy Kandel)

The Colorado Medical Society Alliance recently gave Dr. Richard Krugman, Dean, University of Colorado School of Medicine, a check for \$20,000 for AMA-ERF. The contribution came from CMSA fund-raising efforts in 1995.

Former Alliance President Patti Brown stepped down, as Stella Shanks, of Grand Junction, assumed the presidency during the annual luncheon to install new officers. Mary Jo Ryals, of Pueblo, and Sonja Unrein, of Denver, became the new treasurer and secretary, respectively, for the CMSA.

Michael Jordan teams with organ and tissue donation organization

In response to a critical shortage of organs and tissues, basketball star Michael Jordan has joined a national campaign aimed at increasing the number of organ and tissue donors in the United States. Jordan, veteran star of the Chicago Bulls basketball team, is donating his services to the Coalition on Donation, a national, nonprofit alliance of organizations and local coalitions dedicated to educating the public about organ and tissue donation in the U.S.

The first targeted use of the Jordan campaign materials will be via a partnership with the American Medical Association. Printed materials, such as brochures, posters and counter cards, will be distributed for use in 14,000 AMA members' offices nationwide.

Thomas L. Adams, CAE, named new CEO of MGMA

Thomas L. Adams, CAE, of Madison, Wis., has been named the new executive vice president/CEO of Medical Group Management Association (MGMA), the oldest and largest organization representing medical practice management.

Adams, 45, has served as executive vice president of the State Medical Society of Wisconsin for the past 10 years. He also currently serves on the Advisory Committee to the American Medical Association (AMA) Executive Vice President. Adams will become the fourth chief executive officer in MGMA's 70-year history, succeeding Frederick J. Wenzel. Wenzel has served as the transitional leader since October 1993.

MGMA has a membership of more than 18,700 health care administrators, representing nearly 160,000 physicians nationwide.



AMA calls for divestment of all tobacco stocks and mutual funds

On April 23 the AMA called on investors to divest of 13 stocks and 1,474 mutual funds that manufacture tobacco or invest in tobacco companies calling tobacco a "ruinous and enslaving product that has brought misery, disease, anguish and death."

The 13 stocks are publicly traded companies that manufacture and distribute tobacco products. The 1,474 mutual funds singled out by the AMA reported holdings of tobacco stocks or bonds, according to independent research conducted for the AMA.

"All physicians, health professionals, public health advocates, medical institutions, hospitals and all people interested in the health and welfare of our children should review their investments and divest of tobacco," said Randolph Smoak, Jr., MD, secretary-treasurer of the AMA and a South Carolina surgeon.

The physician organization plans to update and publish the list annually in its publications. In addition, the AMA has written to all 7,000 mutual funds traded in the U.S. asking them to join a "Coalition of Tobacco-Free Investments" by pledging not to invest in tobacco in the future.

Physician information systems taking off

A new study by Frost & Sullivan, a California high-tech research company, finds that physician information system market will grow from \$2.3 billion in sales this year to \$5.6 billion by the year 2001. Currently only about five percent of physicians utilize computers to enter clinical data about their patients.

Managed care seems to be the driving force in the projected increase in sales. Health Maintenance Organization promises of lower health care costs have prompted many providers to go electronic. By networking and demonstrating semi-standardized outcomes data, physicians, hospitals and insurers are meeting the challenge. Analysts find that integration of financial and clinical data through state or national systems is the long-term goal.

New Book on Child Abuse

Child Maltreatment, by Armand E. Brodeur, MD, and James A. Monteleone, MD, is a new clinical guide and reference book on child abuse. While addressing the physical finds in sexual abuse, the reference emphasizes the most important components of the process—disclosure and interview of the suspected victim. In-depth information is provided on medical, psychological, social and legal aspects of child abuse. Readers will learn how to testify in court, and how the legal and social systems process a child abuse case.

The atlas, a valuable reference and teaching tool, presents quality color photos of the various aspects of child abuse, principally physical and X-ray. Emotional aspects are represented by abused children's drawings. For more information please call Danette Anderson 1-800-206-5450.

More expert help for CMS Health Care Financing Division

We are pleased to announce the addition of a new member to the Health Care Financing Division staff at Colorado Medical Society. Marilyn Rissmiller has over twenty years experience in the health care field, primarily in procedure



Marilyn Rissmiller

coding, physician reimbursement, and regulatory issues. She has received her certification from the American Academy of Procedural Coders. In her position as Program Manager, in addition to these areas, she will be assisting CMS physicians with Medicare, Workers' Compensation and Auto No-Fault issues. Marilyn can be reached at 779-5455 or 1-800-654-5653, extension 2428, should you have any questions.



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Ultrasonic instrument cleaner	195.00
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Hemmoroid light coagulator	1,500.00
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EKG's	300.00
EKG's interpretive	1,800.00
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Keystone vision tester	395.00
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Sterilizers	800.00
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Ultrasound w/muscle stimulator	300.00
Olympus flexible sigmoidoscope set	2,800.00
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Slit lamp	1,500.00
OB diagnostic ultrasound portable w/vaginal probe	6,900.00
Gurney	300.00
Cardiac monitors	300.00
Defibrillator	500.00
Cardiac monitor w/defibrillator rechargeable portable	1,800.00
Minor surgery light	395.00
Valley lab electrosurgery	1,000.00
Uterine suction unit	800.00
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OB exam tables w/stirrups	300.00
Liquid nitrogen cryo gun w/temperature probe	500.00
Krymed cryo set w/OB and general purpose tip	695.00
Diathermy	1,000.00
Conscious sedation anesthesia unit w/nitrous oxide & O2	1,000.00
Fetal monitor w/recorder, ultrasound & Toco transducer	1,500.00
Stress test system includes monitor, treadmill & defibrillator	1,800.00
Reflectron blood chemistry analyzer	1,000.00
Kodak Ektachem DT60 blood chemistry analyzer	1,500.00
QBCII 7 parameter w/centrifuge	1,800.00
Hematocrit centrifuge	300.00
Binocular microscope	595.00
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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Reprinted from *The Denver Post*, Sunday, April 14, 1996.

Noted observer says industry is 'appalling'

TV historian sees wasteland

By **Jeannine Aversa**
The Associated Press

WASHINGTON - Erik Barnouw spent his life chronicling the media: He taught Pulitzer Prize-winning author Pearl Buck how to write radio scripts, got Dwight D. Eisenhower's backing for a controversial project on syphilis and saw blacklisting ruin many a career.

Now the 88-year-old retired Columbia University professor, the nation's foremost TV and radio historian, discusses the most important issues confronting TV broadcasters, and much of what he sees he doesn't like:

- The state of today's broadcast television industry is "appalling".
- The V-chip is "dubious".
- Violence on TV is a public disservice.
- He "looks with suspicion" upon TV and radio deregulation brought about by a new telecommunications law.

Barnouw began teaching at Columbia in 1937 and went on to write books about media, film and documentaries as

well as an award winning trilogy, "A History of Broadcasting in the United States" (1966-70), that is still considered the definitive history of broadcasting.

He was a Guggenheim and a Fulbright fellow and chief of the Library of Congress' film, television and recordings archives.

Although a fan of CBS's "60 Minutes," Barnouw says commercial broadcast television has failed to give viewers provocative, cutting-edge entertainment and news programs.

In the beginning, everything was tried - from opera and museum programs to boxing and wrestling matches. But ratings came in the mid-1950s, "one of the worst things that happened", Barnouw says. They standardized programming and killed the spirit of adventure, he says.

Around the same time, TV's switch from live programs to mostly recorded shows had a profound impact, Barnouw says. Action and violence could be portrayed in ways unsuited to live TV.

"So almost immediately it became a cliché — if it was a matter of tracking down some villain,... it always ended with him making a break for it and you had a chase up and down an unfinished building or in a warehouse with boxes falling on people", Barnouw recalls.

"The implication of that is social problems are solved by catching and killing people.... That creates such an infantile, unenlightened mind-set toward the problem of violence", he says.

A recent National Cable Television Association study made the same point about TV shows today.

Although Barnouw believes - as many medical and psychological

experts have said for years - that TV violence can lead to aggressive children, he's not sure the V-chip hailed by President Clinton and other politicians is the answer.

A new law requires all new TV sets to contain the chip, which recognizes shows electronically rated for sex and violence. Parents could then block shows from TV sets. For the V-chip to work, the TV industry must rate programs, which it pledges to do by year's end.

"The idea of abdicating your responsibility to a mechanical entity seems a little dubious," Barnouw says.

Barnouw likes the idea of the government requiring TV stations to air at least three hours of educational shows a week for children - something the industry opposes.

TV stations are given a license to serve the public interest, convenience and necessity. "I think the idea of the public interest is shrinking all the time," Barnouw says.

As more people turn to computer communications for news and entertainment, TV stations will have to find a place in this new world, Barnouw says. "Every new medium that has come along has changed the pattern of getting news and made it more complicated, and that's going to continue to happen."

Editor's Note:

I just couldn't help myself but to reprint this article. Erik Barnouw was for years (in an earlier life of broadcasting) a model of mine. BP



COLORADO MEDICINE

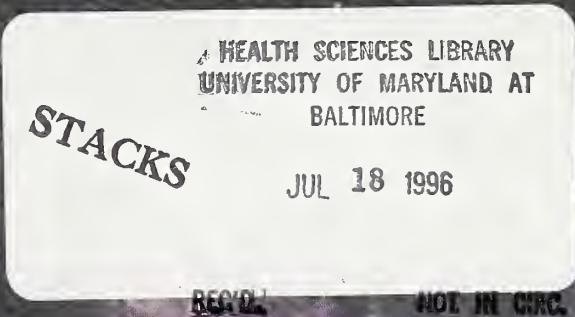
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1996

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TOWARD 2000



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From Star Trek® 1996, KWGN Television, Denver, Colorado

Colorado Medical Society - Into The Future: 1996 Annual Meeting

This Issue:

1996 Annual Meeting Schedule

Annual Meeting & Educational Program Registration

Hotel Accommodations Registration Form

Things To Do In & Around Steamboat Springs

The Future - Keynote Speaker looks at Medicine Toward 2000 and Beyond

COLORADO AND COLORADO

Tentative 1996

Sheraton Resort and Convention Center

September

NOTE: Dress for Annual Meeting

Thursday evening reception: any style from 1871 to present

Friday: casual

Saturday morning: casual

Saturday inaugural dinner/dance: casual or "futuristic"

Sunday: casual

THURSDAY, SEPTEMBER 19

8:00 am –		CMS Office open
9:00 am –		18-hole Golf Tournament
1:00 pm –	2:00 pm	Finance Committee
2:00 pm –	5:00 pm	Board of Directors
4:30 pm –	8:00 pm	Registration open
6:00 pm –	7:30 pm	Welcome Reception
7:30 pm –		Dinner on your own

FRIDAY, SEPTEMBER 20, 1996

7:00 am –		CMS Office opens
7:00 am –	4:00 pm	Registration
7:00 am –	7:45 am	Reference Committee Breakfast
7:00 am –	7:45 am	New Delegate Orientation Breakfast
7:00 am –	7:45 am	AMA Delegation Forum Breakfast
8:00 am –	12:00 N	Exhibits open
7:45 am –	8:00 am	Credentials Committee
8:00 am –	8:30 am	Opening Session House of Delegates
8:30 am –	9:30 am	Alliance Board
8:30 am –	12:00 N	General Membership Meeting
9:30 am –	9:45 am	Coffee break
9:45 am –	11:45 am	Alliance General Meeting
12:15 pm –	1:45 pm	COMPAC/CMSA Luncheon
2:00 pm –	3:00 pm	Alliance Workshop
2:00 pm –	5:00 pm	Army National Guard Physicians
2:15 pm –	3:15 pm	Copic Risk Management
2:15 pm –	3:15 pm	Copic Risk Management
2:30 pm –	4:30 pm	Reference Committee
3:00 pm –	4:30 pm	Alliance County Breakout Sessions
3:30 pm –	5:30 pm	Reference Committee
3:45 pm –	4:45 pm	Copic Risk Management
3:45 pm –	4:45 pm	Copic Risk Management



Activities Available during the 1996 Annual Meeting

This information is provided by the Sheraton Steamboat Resort and the Steamboat Springs Chamber Resort Association published in the Steamboat Springs Summertime Activity Guide.

In Steamboat, you're surrounded by two million acres of National Forest and Wilderness Areas. There are over 150 mountain lakes, two major rivers, hundreds of creeks, dozens of mineral springs and two natural hot springs. Activities abound whether you're spending two hours or an entire week in Steamboat Springs. The following suggested activities will help you plan your days while taking advantage of many of the most popular things to see and do in the beautiful Yampa Valley.

What to do in Steamboat Springs:

Walk, bike or skate the winding paved trail along the Yampa River

Visit scenic Fish Creek Falls

Ride the Silver Bullet gondola up Mt. Werner to Thunderhead Peak

Float high above mountain peaks in a hot-air balloon – 1/2 and 1 hour tours \$80 to \$150 per person

Take a relaxing soak in the Strawberry Park Hot Springs – a 20 minute drive, 10 am to 12 midnight, \$5 per person

Tour the beauty of the area on horseback, daily 1 and 2 hour rides, \$30-35 per person

Learn the sport of fly fishing – \$50-85 per day, license and flies not included

Explore the ski mountain on a mountain bike – \$6 per hour, \$10 for 1/2 day and \$16 for full day

Enjoy a round of golf on a Robert Trent Jones II course while taking in Steamboat's glorious climate

Drive the Flattops Scenic Byway.

Most activities can be booked with Sheraton's Concierge staff, located in the hotel lobby, extension 1005. Prices are subject to change.

Special Events: September 21, 1996

6th Annual Steamboat Fall Foliage Festival and Brewfest – Mother Nature is the star of the Fall Foliage Festival. The aspens that surround Steamboat become the background for polka bands, kindergarten and biergarten, dancers and more festivities.

Colorado Medical Society Annual Meeting

September 19-22, 1996



Sheraton Steamboat
RESORT & CONFERENCE CENTER

*Please call direct for availability of condominiums and other types of accommodations. If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete the following. To guarantee these special rates, **reservations must be received by August 29, 1996**.*

Name _____

Name(s) of additional person(s) sharing room: _____

Address _____

City _____ State _____ Zip _____ Phone () _____

Arrival date _____ Departure date _____

Please reserve the following:

Single Double Smoking Non-Smoking

Payment type

Personal check or major credit card may be used to secure deposit. First night's deposit (room only) per unit is due in our office within ten days from the date the reservation is made.

Type of card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

"I authorize Sheraton Steamboat to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Children 17 and under stay for free in parent's room with existing bedding. Current sales tax is 9.5% (subject to change).

CANCELLATION POLICY: 21 or more days prior to arrival – \$25 per unit. Less than 21 days prior to arrival – Cancellations or reductions in room nights forfeit first night's deposit.

Please let us know how we may accommodate any disability or special request.

Single Rate \$89 + ta

Dbl Rate \$89 + ta

Check-in Time: 5:00 pm

Check-out Time: 11:00 am

Leanne Kaiser Carlson, MSHA, to Keynote Annual Meeting



Leanne Kaiser Carlson, MSHA, an associate with Kaiser & Associates and a member of the International Health Futures Network, will be the keynote speaker at the 1996 Annual Meeting of the Colorado Medical Society. Ms. Carlson is recognized by hospitals and other healthcare organizations across the country for her state-of-the-art knowledge in health futures and the design of healthy communities.

Ms. Carlson will discuss how the flow of information is changing the face of the health care profession. She will explore how technological trends and future components will affect the individual practice of medicine, as well as physician organizations. Look for more details on this presentation, as well as the 1996 Educational Program "Towards 2000" in upcoming issues of *Colorado Medicine*.

CMS Annual Meeting Golf Tournament at the Sheraton Steamboat Golf Course Thursday, September 19, 1996 Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Steamboat I will be staying at _____

I will be attending the meeting in the capacity of (check one)

Physician

Exhibitor

Spouse

Other

I will: Sponsor a golf course hole @ \$100

Sponsor a putting green contest hole @ \$50

Name of sponsor (as you wish it to appear on sign) _____

(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____
I will require rental clubs @ \$25

USGA
 Left handed

Other
 Right handed

If you would like to play please return this entry form as soon as possible because space is limited. CMS has reserved tee times for only eight foursomes. Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$90 must be received **no later than** August 30, 1995. Cancellations received after August 30, 1995 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 879-1391.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

Annual Meeting Registration

1996 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 19-22, 1996, Sheraton Resort, Steamboat Springs, Colorado

Name (please print) _____

Component Society _____ Name of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1995. (Note: To attend the President's Dinner Dance on Saturday, you **must confirm** your tickets before noon, Friday, Sept. 20.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge.** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 19

6:00 pm Welcome Reception member

guest

FRIDAY, SEPTEMBER 20

7:00 am New Delegate Orientation Breakfast member

guest

7:00 am AMA Delegation Forum Breakfast member

guest

4:30 pm CMS Alliance Reception member

guest

(for Alliance members & interested spouses)

5:30 pm Exhibitor Reception member

guest

SATURDAY, SEPTEMBER 21

7:00 am Educational Program Continental Breakfast member

guest

8:00 am Educational Program member

guest

12:15 pm COMPAC Political Campaign Seminar member

guest

7:00 pm President's Dinner Dance:

(Please select menu from below)

Beef and Chicken Dinner member

guest

Vegetarian Dinner member

guest

Vegan Dinner member

guest

9:30 pm Copic Dessert Reception member

guest

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast # @\$15 each= _____

President's Dinner Dance (Reservations necessary, please select menu below)

Beef and Chicken Dinner # @\$50 each= _____

Vegetarian Dinner # @\$50 each= _____

Vegan Dinner # @\$50 each= _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost

Number

FRIDAY, SEPTEMBER 19

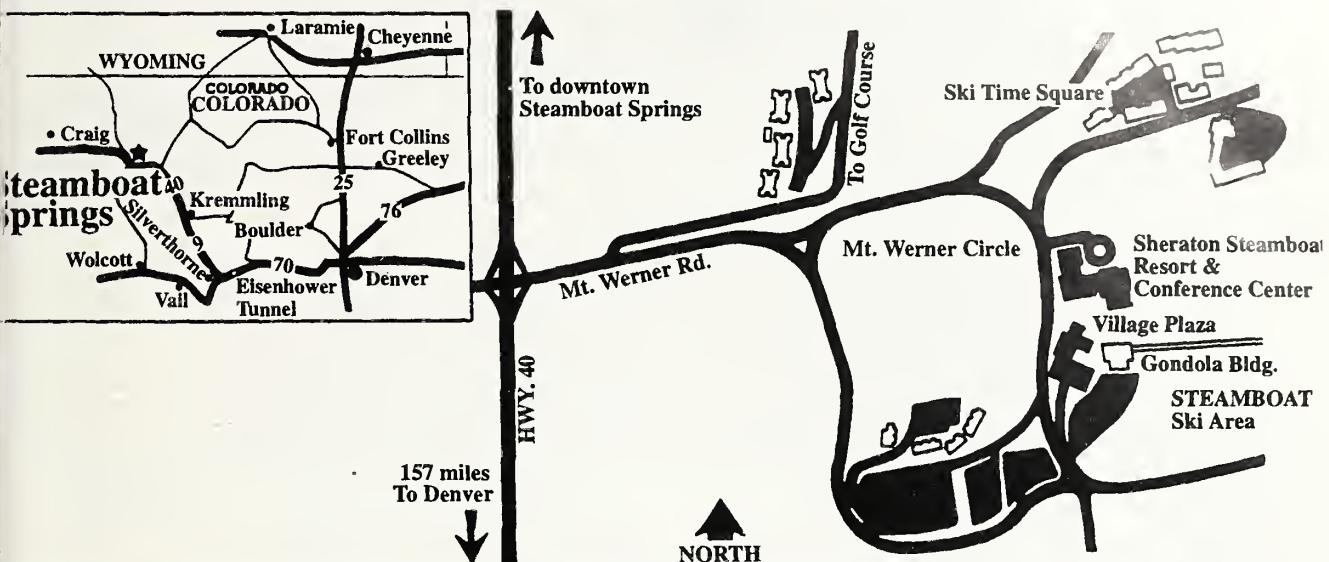
12:15 pm COMPAC/CMSA Luncheon \$20 each

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).

Getting to Steamboat Springs



Call For Nominations

1996 Colorado Medical Society Certificate of Service Award

The Certificate of Service is the highest award given by Colorado Medical Society in recognition of a physician's outstanding contribution to the constitutional purposes of the Society.

1996 A. H. Robins Physician Award

for Community Service

Presented by the Wyeth-Ayerst Laboratories

Criteria for this award are as follows:

1. The recipient must be a physician, licensed within the state of Colorado.
2. The recipient must be living. Awards will not be presented posthumously.
3. The recipient has not been a previous recipient of the award.
4. The recipient has compiled an outstanding record of community service which, apart from his/her specific identification as a physician, reflects well on the profession.

The Colorado Medical Society Certificate of Service Award and the A.H. Robins Award will be presented at the 1996 Annual Meeting, September 19-22, 1996, in Steamboat Springs, Colorado.

Nominations should be made by letter. Deadline for receipt of nominations is July 31, 1996.

Nominations for both awards (with supporting information) should be sent to the **Confidential Awards Committee, Colorado Medical Society, PO Box 17550, Denver, CO 80217-0550.**

Copic Risk Management Seminars

FRIDAY SEPT. 20

2:15-3:15 pm	Family Practice, Internal Medicine – Dr. Thomasson
2:15-3:15 pm	General Surgery, Urology, Genecology (no OB) – Dr. Quinn
3:45-4:45 pm	Pediatrics – Dr. Thomasson
3:45-4:45 pm	General – Dr. Quinn

CMS Seminar "Total Wealth Management Planning"

A seminar sponsored by
The Copic Agency

1:00 p.m. Saturday - 9/21/96

The presentation will address issues regarding:

- Practice Valuation upon sale or merger
- Physician compensation / Income division alternatives
- Employment contract provisions
- Qualified vs. Nonqualified plan
- Balanced Funding Option - An Investment Strategy
- Asset Protection Planning Overview

Leon B. Harrison, CLU, with the COPIC Agency and David L. Lockwood, esq. Attorney and principal with Engel & Rudman, P.C. will be the featured speakers.



AL SOCIETY SOCIETY ALLIANCE

Meeting Schedule

September, Steamboat Springs

1996

FRIDAY, SEPTEMBER 20 (CONTINUED)

4:00 pm –	7:00 pm	Exhibits open
5:30 pm –	7:00 pm	Exhibitor Reception
6:30 pm –	8:00 pm	Women in Medicine Dinner and Business Meeting
6:30 pm –	7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm –	9:00 pm	Gone But Not Forgotten Dinner (by invitation only)

SATURDAY, SEPTEMBER 21

7:00 am –		CMS Office opens
7:00 am –	11:00 am	Registration
7:00 am –	7:50 am	Educational Program Continental Breakfast
7:00 am –	11:00 am	Exhibits open
8:00 am –	12:00 N	Educational Program
9:00 am –	11:00 am	Alliance Meeting
12:00 N –		Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
12:15 pm –	2:45 pm	COMPAC Political Campaign Seminar (Lunch)
1:00 pm –	4:00 pm	Copic Seminar
1:00 pm –	4:00 pm	Army National Guard Physicians
6:00 pm –	6:15 pm	Cocktails - cash bar
6:15 pm –	7:00 pm	Inaugural
7:00 pm –	10:30 pm	Presidents' Dinner/Dance
9:30 pm –	11:00 pm	Copic Dessert Reception

SUNDAY, SEPTEMBER 22

6:30 am –		Reference Committee Reports available
7:00 am –		CMS Office opens
7:00 am –	10:00 am	Registration
7:00 am –	8:30 am	Component Caucuses
	Arapahoe	Denver
	Aurora-Adams	El Paso
	Boulder	Larimer/Weld
	Clear Creek Valley	Pueblo/Western Slope
8:00 am –	8:30 am	Credentials Committee
8:30 am –	12:00 N	Closing Session HOD
9:00 am –	10:00 am	CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD)		Nominating Committee
12:00 N (or immediately following HOD)		Reorganizational Board

**TOSsing AND
TURNING?
CHILLS?
STOMACH PAINS?**

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- Every day, our insureds are finding themselves in new business relationships with new insurance needs; that's why we created our Medical Entity, Hospital, and Provider Stop Loss policies.
- The legislature can play a tremendous role in health care changes; that's why we focus so strongly on our advocacy and lobbying role.

Copic...keeping up with the changes that affect Colorado health care.



Copic Insurance Company

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*Joel M. Karlin, MD
President, 1995-1996*



Three years ago, the Colorado Medical Society responded to the national effort to reform the health care delivery system by establishing policy its members felt should be incorporated into any national or state proposal. The drive towards universal access to health insurance for all Americans, a tenet supported strongly by CMS, has been slowed by the failed efforts of the Clinton Health Plan and the conservative composition of Congress. However, two other priority issues, limiting pre-existing illness exclusions and increasing the portability of health insurance, are still in motion. The Kassenbaum-Kennedy bill could provide up to 25 million more people with health insurance.

A short time ago it seemed that partisan politics would temporarily be set aside and Congress would finally do something to help patients. Unfortunately, unsuspected draconian measures were added to the bill in an attempt to curb fraud and abuse in federal and non-federal health programs. The House in all of its wisdom attempted to reinterpret fundamental legal principles when it revised HR 3103. The burden of proof in our legal system currently rests on the accusing party, and requires proof of "knowing and willful" intent on the part of the perpetrator to commit such offenses. Under the new bill offenses, even as minor as "incorrect" claim coding, could lead to civil and criminal penalties, including fines as high as \$10,000 per violation. In one day, a careless bookkeeper could lead to your demise!

All physicians, I believe, deplore

fraudulent and abusive schemes which undermine health care delivery and lead to unnecessary expenditures. Coding is subjective at best, and physician variations should be reviewed. However, they should not become the basis for such harsh penalties. Penalties for conviction of such acts should be commensurate with the offense committed. The House proposal went too far by eliminating the "knowing and willful" standard. Moreover, the revised law also stipulated that if a patient died as a result of fraud, then a "life in prison" sentence could be imposed.

In response to the revisions to the Kassenbaum-Kennedy bill, the American Medical Association (AMA) launched a grass roots campaign to inform doctors throughout the country of these onerous provisions. Members of Congress began to receive calls and letters from physicians nationwide, and our AMA implemented an intense lobbying effort directed towards Congressional leadership.

As this article goes to press, I am pleased to report that significant changes have been made to HR 3103. The "knowing and willful" intent standard has been reinstated, and physicians will not be subject to criminal penalties for non-deliberate actions. Monetary penalties will be assessed only after a physician demonstrates reckless disregard for the truth in dealings with Medicare. Other significant issues still need to be resolved, but the likelihood of my bookkeeper "sending me up the river" has diminished.

Anything can still happen as the

"...a careless bookkeeper could lead to your demise!"

bill continues through the legislative process. It is important for all of us to keep a vigilant watch. Call the toll-free AMA "hot line" at 1-800-833-6354 for the latest information. This one free call will also allow you to be directly routed to your two Senators and Representative. Tell them about the positive effects the bill will have in addressing the problems of portability and pre-existing illness, and voice your concerns regarding the fraud and abuse provisions.

Three years ago CMS answered the call and acted on behalf of all Colorado physicians. That charge continues today. Once again the AMA has similarly demonstrated its commitment to the entire profession of medicine. The AMA deserves much credit for championing the cause of physician members and nonmembers alike.

Physician Recognition Awards

The Colorado Medical Society joins the American Medical Association in recognizing the following physicians for their dedication to excellence in the profession of medicine, as demonstrated in their commitment to continuing medical education.

David Michael Abbey
David Michael Barrs
Richard Ferrandou Bedell
Francesco Gallatin Beuf
James Gilbert Chandler
Zenaida Tecson David
William G. Espan
Thomas Melvin Golbert
Lawrence Ned Gorab
Glenn Olton Hewitt
Steven A. Holt
William Inkret

William Lee Jurgens
Kenneth Harris Kaplan
Lloyd Lee Kemeny
John Stephen Lemley
Thomas Paul McAnally
Anthony Jos Makowski
Ann Louise Mattson
George Horner Maxted
Martha C. Middlemist
M. Keith Miller
Ronald Scott Murray
Perlita Acuna Narvaez

Roger W. Narvaez
Bruce Roland Overturf
Garold Lynn Paul
Jay Alan Richter
Kathleen Yumi Sawada
Michael Jos Sorensen
Marc Joel Sorkin
Ronald Jean Swarsen
Michael Jos Whistler
Patrice Gendel Whistler
Denis Jordan Winder

LEGAL UPDATE

Employers at Risk

Employment law is a diverse area that is controlled by judicial decisions, as well as legislative enactments.

An employee who is hired in Colorado for an indefinite period of time works "at-will." The employee may quit when the employee wishes, and may be terminated by the employer without cause. Notwithstanding the apparently clear rule that an employee may resign or be terminated by an employer without cause, employers must be aware that there are several theories upon which an "at-will" employee can bring an action for wrongful termination. For example, a suit may allege that an employee handbook outlined procedures and policies that essentially constituted a "contract," and that termination procedures in the handbook bind the employer. If a handbook does not expressly disclaim being an employment contract, an employer risks having to adhere to

the termination procedures.

A growing area of liability is based on a legal theory called "promissory estoppel." The essence of promissory estoppel is that, even in the absence of an express contract, an employee may hold an employer to implied promises of long-term employment.

An employer's responsibility to a terminated employee does not end until all wages have been paid. Colorado law requires, under most circumstances, that wages earned by an employee in any employment be paid within ten days following the close of a pay period. Upon termination, employees are usually entitled to be paid immediately.

The classification of independent contractor continues to draw interest from the state and federal governments. An employer generally has no withholding or workers' compensation obligations with respect to independent contractors, while the burdens associated with employees may be

*from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000*

substantial. The IRS utilizes twenty factors to be applied in making a determination of whether a worker is an employee or an independent contractor.

Colorado law provides that an individual is considered to be an "employee" unless it can be shown that such individual is free from control and direction in the performance of the service or is customarily engaged in an independent trade, occupation, profession, or business related to the service performed.

Employment law is a growing area of concern for employers. The subjects discussed above are only a few areas in employment law that deserve attention.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Changes on the way for CME?

The Accreditation Council for Continuing Medical Education (ACCME) is currently undergoing revisions to Continuing Medical Education (CME) accreditation. Rising costs for running CME programs, the need for uniform standards of accreditation, and the changing effect of CME on physician learners and on patient outcomes are driving factors for change.

The ACCME gives recognition, authority and general supervision for state and territorial medical societies which are responsible for operation of intrastate accreditation programs. The members of ACCME represent all of the major organizations with an interest in continuing medical education. They are: American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Medical Boards, a federal representative and a public representative.

The Colorado Medical Society Committee on Professional Education and Accreditation hosted a half day regional meeting on June 17 to discuss the changes in the accreditation process. Drs. Murray Kopelow, ACCME Executive Director and Charles Daschbach, ACCME Council member, fielded questions from representatives of state medical associations from Arizona, California, Nevada, Utah and Wyoming, as well as selected CME staff and physicians in Colorado who chair or direct CME programs.

University Hospital, TriWest land \$2.5 billion health care contract with Department of Defense

The US Department of Defense awarded TriWest Healthcare Alliance a five year \$2.5 billion contract on to serve as prime contractor for the government's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) TRICARE program in a 16 state region. Colorado shareholders include University Hospital, University Physicians Inc. and the CU School of Medicine faculty physician multi-specialty group practice.

The basic framework of the Council's plan consists of a tiered system including a "first-step" program of "traditional" CME (lectures, seminars, etc.) complemented by added competencies such as joint sponsorship, preparation of enduring material and personalized education. The latter is founded upon varying degrees and methods of evaluation of the impact of CME on the physician learner and on patient outcomes.

Currently the functions of the ACCME are:

- 1) To set uniform standards of accreditation;
- 2) To assure uniform equitable application of the criteria for accreditation to programs regardless of their location, and;
- 3) To establish uniform types and duration of accreditation.

Dr. Kopelow is visiting all of the regional CME districts in an attempt to further understand the increasing financial constraints and other concerns faced by state CME programs. The ACCME is looking to the component state societies to flesh out the principles outlined during such meetings. State societies will discuss these proposals and respond to the Council's plan in the near future.

The CMS currently accredits 35 programs on an intrastate basis. For more information on CME in Colorado please call Lorraine Heth, Program Manager, CMS Division of Health Care Policy, at (303) 779-5455 or 1-800-654-5653.

One year ago University Hospital joined with 13 health care organizations in 16 other states to form TriWest Healthcare Alliance. A proposal was then submitted to the US government to provide comprehensive medical services to the military. TriWest is owned by 11 Blue Cross/Blue Shield plans, a for-profit HMO in Nevada, and two University Hospitals, in Colorado and New Mexico.

(Continued pg. 3)



Med Fax: Medico- Legal News

by *Timothy M. Schulte, Esq. and Karen B. Best, Esq.*,
associates with the law firm
of *Montgomery Little & McGrew, P.C.*

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Removing children of divorce from the state . . . (continued from last month)

"If restrictions against leaving the state with the child are contained in the dissolution decree or separation agreement, the custodial parent requesting the removal has the initial burden of proving that removal is in the child's best interest. However, a *prima facie* case for removal is established when the petitioner shows a sensible reason for the move and that the move is consistent with the child's best interests ... Once a *prima facie* case is established, the burden shifts to the non-custodial parent. Thus, the court should grant removal unless the non-custodial parent proves that the child's move outside the state with the custodial parent is detrimental to the child's best interests." *Murphy* 834 P.2d 1287 (Colo. App. 1992). Thus, after the *Murphy* case, when the custodian has restrictions on leaving the state, the burden at least starts with the custodian, but ultimately falls on the non-custodian.

What happens in a joint custody arrangement? When Mom and Dad are joint custodians, there is particular emphasis on the importance of each in the life decisions regarding their children. Are the burdens and standards different? Colorado first addressed this question in 1995 in a case in which the parents had joint custody and Mom was the primary residential custodian. The parents had agreed to continue to reside within 60 miles of downtown Denver. Mom later wanted to move to Arizona because her fiance had obtained a job there. The Court of Appeals held that "each parent has the burden to persuade the court that his or her new parenting plan should be adopted." The burden is shared equally. The Court also noted that in joint custody arrangements, if the non-residential custodian spends a significant amount of parenting time with the children, the "existence of a joint custody order may be considered in determining whether removal is in

the child's best interests." Thus, it would appear that as a joint custodian, even if one is the primary residential custodian, he or she may not have the same latitude to move as might be found in a sole custody arrangement.

The common thread through all the cases is consideration of the best interests factors, which include: 1) whether there is a sensible reason for the move by the custodial parent; 2) whether there is a reasonable likelihood the proposed move will enhance the quality of life for the child and the custodial parent; 3) whether the court is able to fashion a reasonable visitation schedule for the non-custodial parent after the move; 4) what are the motives of the non-custodial parent in resisting removal?; 5) whether the non-custodial parent's motion to prevent removal is, in effect, a request for a change of custody and none of the provisions of S14-10-131 respecting change of custody have been established by the evidence; 6) what are the practical effects of an order denying the custodial parent's request for removal, that is the emotional harm that may be presumed to occur to the child if it is necessary or desirable for the custodial parent to leave the state and the child is not permitted to go.

The lesson in all of this for those about to enter into a separation agreement, or about to litigate questions of child custody and visitation, is that the ability to move out of the state in the future will be impacted by many factors, including the child custody order (sole vs. joint custody) and by the amount of parenting time awarded and actually exercised by a non-custodial parent. However, regardless of all of this, the best interests of the children are paramount.

For further information concerning this or any other domestic relations topics, call Timothy Schulte, Esq., or Robert Beattie, Esq., at Montgomery Little & McGrew, P.C., who concentrate their practices in the area of family law, including divorce, child custody, visitation, child support, maintenance, property division and adoptions.

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CMS Med Fax

(CHAMPUS cont. from page 1)

Under the TriWest contract, University Hospital and its 13 partners will manage a regional network of hospitals and more than 13,000 doctors. In Colorado the network will provide comprehensive health care services to an estimated 130,000 CHAMPUS-eligible patients. Colorado patients will be cared for through the Health Care Colorado network of local providers.

"The award of this contract to University Hospital and its partners is a real tribute to the quality and service provided by our physicians, and an opportunity to strengthen our ties with health care communities across the state," said Dennis Brimhall, president, University Hospital.

The contract is to care for the dependents of active duty military personnel and retirees and their dependents under 65 in the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration.

National HIV Telephone Consultation Service

The National HIV Telephone Consultation Service, "Warmline" (800-933-3413) based at San Francisco General Hospital provides free HIV clinical information and case consultation to health care providers. The Warmline faculty includes physicians, clinical pharmacists and nurse practitioners who have extensive experience treating patients with HIV disease. Warmline consultants are available to answer questions between 7:30 AM and 5:00 PM PST. A twenty-four hour voice mail system is available at other times.

The Warmline is funded by the Health Resources and Services Administration, the AIDS Education and Training Centers and the American Academy of Family Physicians.

Fourth Annual Medical Informatics Fair

The Denver Medical Library will hold its Fourth Annual Medical Informatics Fair at Columbia Presbyterian/St. Luke's Medical Center, on September 26-28.

The fair has become the largest event of its kind in the Rocky Mountain Region. Aimed specifically at physicians, office managers and other health care personnel interested in computer applications in medicine, the fair is organized by the Denver Medical Library, hosted by Columbia P/SL Medical Center, and sponsored by leading health care organizations, including the Colorado Medical Society, the Denver Medical Society, Copic Insurance Company and the Colorado Foundation for Medical Care.

In lectures, workshops, hands-on seminars and a broad array of vendor exhibits, the Medical Informatics Fair offers the medical community a chance to immerse itself in the world of information systems. This year's theme is "The Internet." Topics will include:

- Medical Web Sites
- Navigating the Internet
- Internet security
- Private internets and intranets
- Composing in HTML
- Tickler systems
- Patient access to medical information
- Connectivity: Hospital, Physician, Insurer
- Liability issues created by computerized medical records

In addition, there will be commercial displays and educational presentations on every aspect of medical computing, including: office automation; billing; electronic claims; electronic medical records; E-mail, scheduling, communications, EDI; decision support; medical references; patient education and; other topics in medical information management.

For more information please call Dorothy Struble, at (303) 839-6670.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Universiy of Colorado's CME in the Rockies

23rd Renal Disease and Electrolyte Disorders
July 22-26, 1996
Aspen, Colorado

1-800-882-9153 or (303) 372-9050

Colorado Otolaryngology and Maxillofacial Society

The Cutting Edge of Otology
July 24-25, 1996
Doubletree Antlers Hotel
Colorado Springs, Colorado
Contact: Bob Conlon, MD or Debbie Brown
(970) 484-8686

American Psychiatric Association

Dynamic Psychotherapy in the New Era
July 29-August 2, 1996
Aspen, Colorado

18 Hours CME Credit, Category 1

Contact: Maria Gorrick (202) 682-6145

American College of Cardiology

Echocardiographic Symposium on 2-D and Doppler
Echocardiography
July 29-August 1, 1996
Vail, Colorado

23 Category 1 AMA

(800) 253-4636

University of Colorado's CME in the Rockies

21st Primary Musculoskeletal Care Conference
August 4-9, 1996
Breckenridge, Colorado

(303) 372-9050 or 1-800-882-9153

University of Colorado's CME in the Rockies

39th Annual Pediatric Program
August 4-8, 1996
Aspen, Colorado

(303) 372-9050 or 1-800-882-9153

University of Colorado's CME in the Rockies

1st Annual Aspen Brain Tumor Symposium
August 11-13, 1996
Aspen, Colorado

(303) 372-9050 or 1-800-882-9153

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
August 22-23, 1996
Englewood, Colorado

(303) 397-7876

Colorado Commision on Family Medicine

1996 Opportunities Fair and Annual Conference
September 6-8, 1996
Copper Mountain Resort, Colorado

(303) 745-4275

American College of Cardiology

Enhancing Quality and Value in Cardiovascular Care
September 18-21, 1996

Vail, Colorado

22 Category 1 AMA

1-800-253-4636 ext. 695

Rky. Mtn. Cardiovascular & Health Promotion Conf.

CU School of Medicine and Office of CME
September 19-20, 1996

Vail, Colorado

(303) 372-9050 or 1-800-882-9153

HIV Clinical Training Program

Col. AIDS Educ. & Training Cntr. and UCHSC
September 18-20, 1996

Denver, Colorado

(303) 355-1305

University of Colorado's CME in the Rockies

Rky. Mtn. Correctional Health Care Conference
October 1996

Denver, Colorado

(303) 372-9050 or 1-800-882-9153

University of Colorado's CME in the Rockies

42nd Family Practice Review
October 28-November 1, 1996
UCHSC, Denver, Colorado

(303) 372-9050 or 1-800-882-9153

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An opportunity to recruit well-trained, enthusiastic Family Practice Physicians and their families!

A recruitment event without the "we" "they" environment.

An excellent rate of return on **your** investment: 60% of the participants at the **1995 Opportunities Fair** recruited at least one Family Practice Resident – all 1996 graduates.

Five Family Practice Residents were recruited for a rural community!

For additional information contact Commission on Family Medicine: 2851 South Parker Road, Aurora, Co 80014, (303) 745-4275.

CPN*

is on its way!

*Colorado Physician Network

On Tuesday, May 14, 1996, the Colorado Division of Insurance announced that the Rocky Mountain HMO (RMHMO) license had been extended to the entire state of Colorado. This is the final step needed for **Rocky Mountain Physicians' Choice** to become a reality!

We have recruited over 2000 physicians; we have contracted with hospitals throughout the state; we have publicized the unique features of this new generation of managed care programs in the public media; and now we can market the product!!

Phase I will focus on the Southern Front Range: Colorado Springs, Pueblo, the San Luis and Arkansas Valleys, and the Eastern plains; Northwestern Colorado in the Craig area will also be included. Subsequently, we will emphasize the Denver Metro area and the remainder of the state.

Our staff will be contacting the offices of CPN members in the weeks ahead to provide the materials and education needed for implementation. Simultaneously, employers in your community will be offered the opportunity to purchase the product.

Thanks to all of you who have supported this bold move by Colorado physicians: Our Dream is now a Reality! "You never had it so well"!!

David C. Martz, M.D.
President, CPN

Sandi Maloney is on vacation. Her column, "Executive Director's Update", will appear next month.

Physician Consultant Update



Leigh Truitt, M.D.

“... problems with deselection from managed care?” There's still help available.

During the past few months, I have completed a Resource Guide: Programs of Assistance for Physicians. This is an attempt to summarize in a systematic fashion the activities of the Colorado Foundation for Medical Care, Colorado Board of Medical Examiners, Colorado Physician Health Program, and Colorado Personalized Education for Physicians that affect physicians. Many physicians are under significant stress in their medical practices and personal lives for a variety of reasons. We are fortunate in Colorado to have these organizations available. I would urge you to consider using the resources provided by these entities to obtain help before your practice or personal life suffers harm. The Resource Guide is available from the Colorado Medical Society offices through Debbie Jones at (303) 779-5455 or (800) 654-5653.

I have spoken to several of our component societies on credentialing, managed care formularies, physician practice profiling and other managed care issues. If any organization would like to hear more about these topics or physician selection and termination by managed care plans, please contact me at (303) 321-2598. These presentations are based on the six health maintenance organizations that I surveyed last summer for the CMS plus additional information from the literature.

In the last five issues of Colorado Medicine, I have listed articles from the current literature on a variety of managed care topics including the roles of primary and specialty care,

utilization management, supply and demand for physician services, physician hospital organizations, capitation, and vertical versus virtual integration. The articles are available from the CMS offices if you can't find them in your own medical libraries. If this has been of interest to you, please let me know and I will continue to compile the lists periodically.

I have also spent some time working with a subcommittee of the Data Committee of the CMS looking at physician practice profiling by managed care organizations and group practices. A trend in the industry appears to be to push down physician selection, credentialing and practice profiling to the level of physician hospital organizations. Practices vary widely and it is difficult to determine what is being done let alone what should be done. We will continue to work on this issue and next explore some commercial systems that are available.

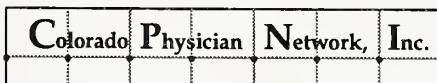
In addition, I continue to try to help individual physicians who are having problems with deselection from managed care provider panels or other problems with their practices. In general, I have found the managed care organizations open to working through these situations and have been able to suggest solutions to these problems in some instances. Please call me at the number above, if you need help. These services are provided through my role with the CMS.

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**Congratulations to the 2,100 member-physicians
who made it happen!**

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LETTERS

Dear Editor:

I have undertaken a project to write a paper about the 29th Army Hospital of World War II based on the letters my father wrote home, which my mother saved. In some ways this gives one insight into the unit that did not appear in the press releases of the time. My primary focus at this time is on the anesthesia aspects both within the unit and the practice of anesthesia in the South Pacific in the 1940's. I have also found among my father's effects other items including resumes of each member of the unit and pictures of the hospital, personnel, etc.

In the 1944 letters, father tells of a display he developed on blood transfusions. Although its prime objective was for use by the military, it was successful enough that it was presented at the 1944 Annual Meeting of the Colorado Medical Society under the auspices of the University of Colorado School of Medicine.

Are there any records of this exhibit in the files of the Colorado Medical Society? If you should find anything pertinent, I would appreciate it if you would let me know.

I believe that almost all of the physicians of original 29th from Colorado have passed away. However, should there be any still living, or if members of their family have any information, I would like to get in touch with them.

Thank you for anything you might provide.

Donald W. Stein, MD
Tucson, AZ

Data Communication

Dear Editor:

I read the articles by your members in the April, 1996 issue of *Colorado Medicine* with intrigue. I have a great deal of interest in these issues and have been converting my own practice and records into being computer based. The biggest obstacle I have encountered is importing patient data generated by outside sources. These outside sources include hospitals, laboratories, radiology, consultants, colleagues, etc. The methods used to import data have been mostly scanning and OCR (optical character recognition). These methods are not satisfactory, because they are time consuming, and not always accurate.

The problem I have faced will become more common as more practices use computer based medical records. To solve it, I believe efforts should be made at the Medical Society Level to implement a system of transmitting reports and data electronically employing the HL7 standard as a format. Security, of course, would be an issue. But if we look at the parallels in the paper world, reports are sent by mail and by fax today. Data could be sent electronically, at the most basic level, on a floppy through the mail or delivered by courier and be as secure as any paper report. One level up the data could be sent as a file attached to a fax that can be handled by a variety of fax software programs. It is vital, that standardization of the file format be enforced. Standardization, will allow a variety of physician users and a variety of

programs to access the data. A legitimate concern, is that a powerful conglomerate health organization could lock up and control patient data through use of proprietary format and encryption routines. I believe implementing a standard now will protect individual physicians in the future. The standard that should be implemented, is the HL7 standard. This is an open national standard and therefore will enable communication for Colorado physicians with health care providers across the country.

The steps that should be taken now include:

- Devise a standardized request to vendors of data that in addition to issuing a paper report, that an electronic report be issued. I believe making this a standardized request will make it less of a burden on the vendors than receiving multiple customized requests and make them more likely to cooperate.
- Encourage producers of medical data to report in the HL7 format. For example, radiologists would be asked to break their reports into Findings, Interpretation and Recommendation segments. Specialty societies should be involved in implementing this. Hospitals and commercial laboratories would be appropriate early targets.
- Provide software for physicians and vendors to use for importing and exporting HL7 files. This software should be written for a variety of platforms to encourage widespread use. It should be either freeware or shareware and posted

to the CMS page on the Internet and also be available by mail.

I would be happy to further correspond or discuss these issues with you and assist in any implementation of the above. Thank you for your attention.

Eric H. Leder, MD
Denver, CO

Michael S. Victoroff, MD, Chair of the CMS Medical Informatics Committee, responds to Dr. Leder.

Dear Dr. Leder,

We need more doctors like you, complaining about the disarray of our information systems!

I've been using an electronic medical record for 7 years and I still can't get anyone to talk to me!

HL7 is a hospital laboratory data standard, devised under the auspices of ANSI (The American National Standards Institute). It's widely (but not universally) used for lab result reporting, and has spread somewhat to other hospital transactions, like admission, discharge and transfer messaging between departments.

HL7 hasn't caught on much with clinicians, because of its complexity, its weakness with text, and other limitations in non-hospital settings. It competes with the ANSI X.12 standard (same body two standards!), which is strongly supported and being adopted widely for the exchange of insurance billing and payment transactions. (Remember, billing transactions have essentially defined what "diagnosis" and "procedure" are in medicine today.) HL7 is inadequate to handle many of the fields needed for claims data.

Of course there are many other standards. Some of them address the message *envelope*, others are aimed at the *content* and some seek to do both. Some are narrowly specialized, some are general. All have devotees in both the academic and commercial worlds, and all have millions of dollars riding on them.

Like yourself, each of us who has found an agreeable format for

our own data wishes everyone else would use it, too. Unfortunately, what suits you might not work for me.

For the past 2 years, ANSI has convened a highly political, "Health-care Informatics Standards Board," to find common ground. It will happen in our lifetimes, if our cholesterol is very low.

Some think the answer is to not force everybody's data into one format. Instead, "translation tables" could be created that convert a small number of "best of breed" standards. However, such a design would require every programmer to support multiple formats.

The growing availability of Internet database servers may provide a much easier solution to the "envelope" problem, if you can accept data in HTML format. The Colorado Health Electronic Data Interchange Advisory Board (CHEDIAB) has been working for several years to coordinate the content of data communication among providers and payers. Several Community Health Information Network projects have been designed for Colorado, and there are numerous commercial networks (proprietary and Internet based).

Columbia has enough mass to create its own network and plans are being made to implement such a project. Walgreens will introduce a prescription management network to Denver this fall, and at least one other pharmacy chain is talking about the same thing.

Into this serene environment, you've introduced one idea I like, one I'm skeptical about, and one that's just plain wild.

- 1) I agree that the CMS (which has utterly no influence on vendors or insurance companies, since it doesn't buy software or submit claims) should join the voices clamoring for more electronic interchange. Amen.
- 2) However, I would not want the CMS to jump on one particular political bandwagon, while groups with far more influence and sophistication are still debating the issues, and the "ultimate, true and final" standard is just

around the corner.

3) Finally, I can't imagine how the CMS could "Provide software... to use for importing and exporting HL7 files." We don't have a programming staff or a software development budget. If you're talking about communications software there's a ton out there, including shareware for any platform. If you're talking about some "official CMS office based medical records system," don't hold your breath. Vendors for years have been trying to get the CMS to endorse their systems, and we've wisely abstained. What a tar pit that would create!

But that brings us to the crux, right? Why would anyone send you their data, if they could? Where's the money in it? All you want is better patient care, reduced redundancy, fewer errors, improved efficiency, less waste and delay, more safety, convenience and reliability. Unless you can show how that will make money for whoever holds the data, you can forget about getting it. Getting *our* data, on the other hand, is another matter. Not to be cynical.

Then, of course, once we have achieved electronic data interchange (EDI) in its ideal form, we'll discover that we are utterly unprepared for the new challenges this creates concerning information security, privacy, disclosure, research, storage, destruction, subpoena, fraud, vandalism, discrimination, liability and a few other areas.

But keep yelling. It's starting to happen.

Please contact the CMS Medical Informatics Committee with your thoughts. You can harass them at "informatics@cms.org".



When you make the decision...

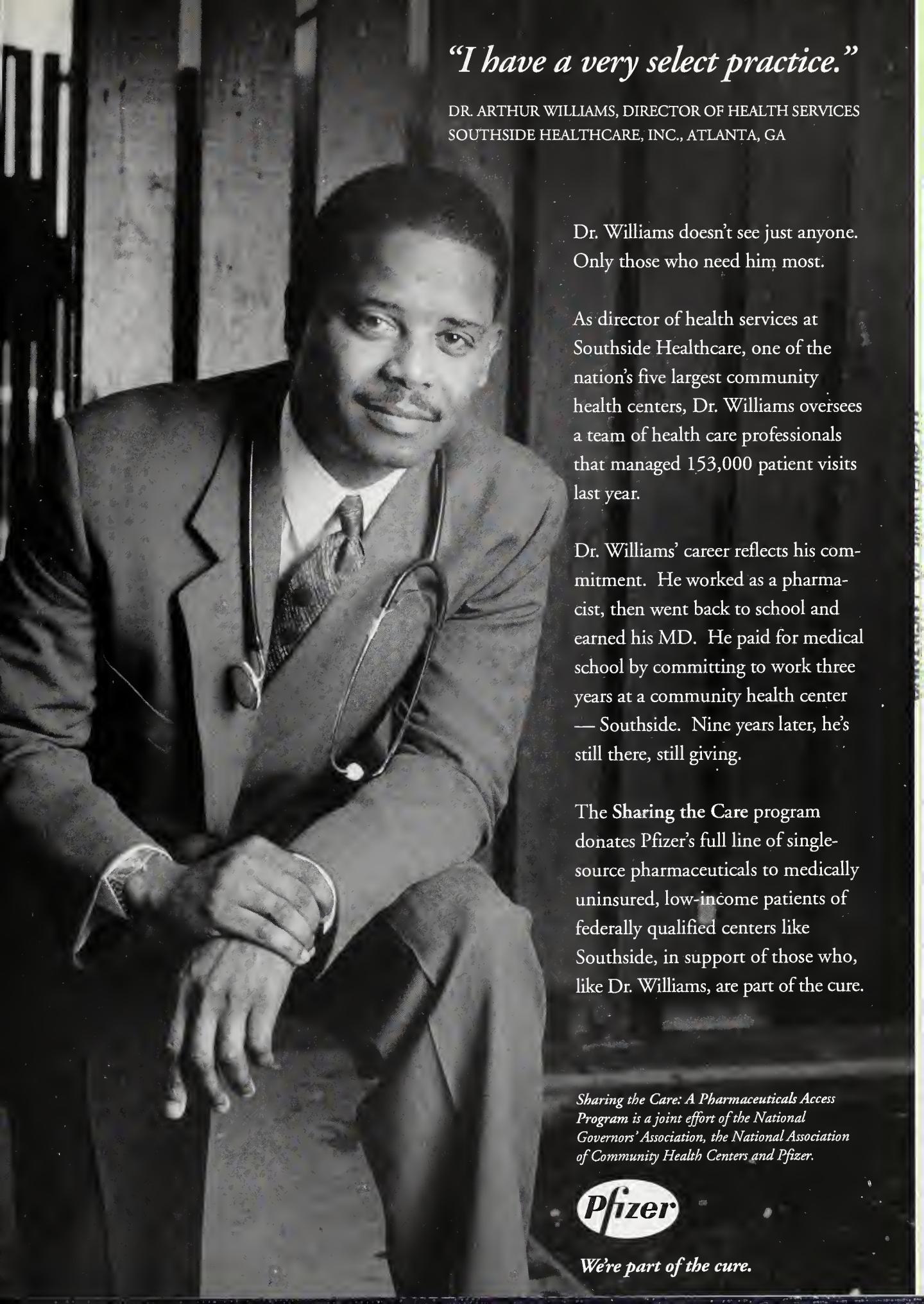
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DR. ARTHUR WILLIAMS, DIRECTOR OF HEALTH SERVICES
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Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

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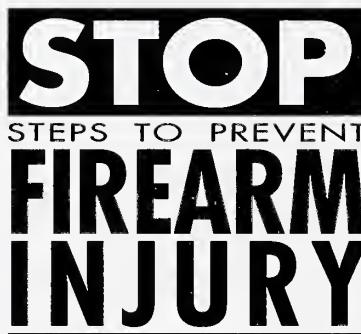
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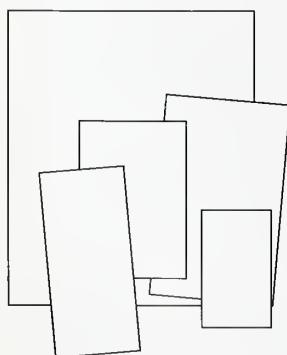


A joint program of the American Academy of Pediatrics and the Center to Prevent Handgun Violence

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State _____

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Return to: Center to Prevent Handgun Violence, P.O. Box 8303, Easton, MD 21601-8303

Gun Safety: The Physician's Role

by Mark B Johnson, MD, MPH,
Chair, CMS Youth Task Force and
Holly Hedegaard, MD, MPH

The debate surrounding guns and gun safety is one of the most contentious topics concerning public health today, and the controversy has not left the Colorado Medical Society (CMS) untouched. Last year the Youth Task force of the CMS Health Affairs Council was asked to study the issues. This led to the adoption of Resolution 14, IM '96, which charged the CMS, in collaboration with the Colorado Medical Society Alliance and other groups, to begin a multifaceted program "to encourage physicians in the State of Colorado to use firearm safety education materials in their offices and to counsel children and parents on the risks of keeping a gun in the home, as well as the danger of firearms in the community."

The Youth Task Force has been diligently working on ways to implement this program. Various materials that have been produced by national groups have been examined, and methods for the dissemination of information have been explored. The program that appears to be most appropriate for physicians is called "STOP, Steps to Prevent Firearm Injury." STOP is a partnership project of the Center to Prevent Handgun Violence and the American Academy of Pediatrics. This education program is designed for health professionals to use when counseling parents on the risks of keeping a gun in the home. In addition to being a well prepared program made especially for physicians and other health care providers, it is available **free of charge**.

Firearms account for over 39,000 deaths,¹ 100,000 hospital

emergency department visits,² and \$20 billion in health care costs annually in the United States.³ In 1994, it is estimated that there were 508 firearm-related fatalities in Colorado, and 350 people were admitted to Colorado hospitals for nonfatal firearm-related injuries.

Accounts of the unintentional shootings detail how prevention and education programs can help. Fifteen injuries occurred when the victims were walking around with a gun, picking it up or laying it down, or putting a gun in a pocket or holster when it accidentally went off. Five involved shooting a gun outdoors. Six occurred when playing around with a gun or jokingly pointing a gun to their head when it went off. Six other people were injured when cleaning, loading or unloading a gun. Two victims accidentally shot themselves at home while drinking or doing drugs.

Gun violence is a public health issue, and doctors can play a vital role in preventing it. Studies have shown that households with unlocked, loaded guns present risks for unintentional childhood firearm fatalities. Safe gun storage education is needed.⁴⁻⁷ The ready availability of firearms is also associated with an increased risk of suicide in the home.⁸ Physicians are natural messengers of health and safety information. They can give parents and children clear-cut steps to reduce the chances of unintentional and intentional gun incidents. To receive a **free** packet of the "**STOP, Steps to Prevent Firearm Injury**" materials please see the tear off coupon on preceding page.

"Gun violence is a public health issue, and doctors can play a vital role in preventing it."

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A

few selected thoughts regarding this man. . .

*K. Mason Howard, MD
Chairman Emeritus
Copic Insurance Company*



Eulogy given by Dr. Howard at services for Dr. Lewis on June 12, 1996

Jeannie, Betsy, Susie, Candy, Tom and Fred, and each of you gathered here today:

There is in me the eerie sense that I, or perhaps we, may be here to say things in remembrance of Fred which should better have been said to his face over the many years we loved him, his family, his strengths and his foibles. I hope that is not the case, but we are here today to profess our love for him.

There may be things I won't properly address, 'cause my acquaintance with Fred dates back only twenty-five years, about a third of his lifetime. But ignoring that, let me venture into a few aspects of the life of this friend and colleague, remembering just a few of the things which characterized the man and what he's meant to me, and to all of you.

Fred was a man of many faces and talents who produced many masterpieces. He had a loyal group of patients who consulted with him for many years, and who were helped in ways known only to them and to him, as only that should be.

Jeannie recalls that many, many times when they were out socially, Fred would meet a patient, and that encounter would be especially considerate and kind, a quiet understanding between the helper and the one he had helped.

And what about his laugh?

Don't you all have a memory of something that tickled Fred, and his laughter, which could not be mistaken for that of anyone else? Jayne and I will miss that laugh, that unrestrained joy and empathy it purveyed to all around.

Computers: Fred surpassed everyone around in the gadgets he had, and his expertise in manipulating them. He and his children, (and sometimes reluctantly his wife), did a lot of communicating around the computer, sharing programs, expertise, games, modems, or what have you — a sharing characteristic of a man who was ahead of his generation and had moved to master a technology which most of us fear.

But speaking of masterpieces, let's talk about the five children he and Jeannie have raised; five wonderful individuals who have been cared for, prodded, pushed and pulled, by a father who loved them deeply and understood them individually. The successes of these kids are well known -- I think none of us have tribes who are as brilliant and accomplished as are Candy, Fred,

Susan, Betsy and Tom. Here are five individuals in the helping professions who like each other and their parents. Another generation of Lewises is coming along; two grandsons so far, and a great legacy to leave behind.

If you didn't know Fred and Jeannie during the time these five wonderful children were still growing up, there are still some memorable legends which grew from those years.

Along the way of raising that family, some unique stories emerge. First, each morning found the tribe at the table, Dad perusing the Post, The Rocky and the Wall Street Journal, Mom bringing the food, and the kids in hushed silence 'lest they arouse the wrath of their father who was reading the papers. Breakfast was not a time for joviality and togetherness in the Lewis household.

Another snippet from the Lewis family history relates to how Fred and Jeannie dealt with schools, mostly in the Cherry Creek District. Jeannie spent many hours camped in the offices of various principals, teachers, counselors and the like, assuring that those five bright and productive young students got what she wanted from a school; while Fred, not really satisfied with what he saw going on in the school system, decided he'd walk the district in which they lived, garner the needed support, and get himself elected to the School Board. Fred didn't make it onto the School Board -- the District to this day has no sense of what they missed -- but I suspect his influence was felt, even without success in local School

Board politics.

In addition to his family and practice, Fred was ultimately successful in both membership participation and leadership roles in many peer organizations.

As a lifetime member of the American Psychiatric Association, Fred may well have served that Association longer than any other member in various committee and other functions. All of us have gone to "medical meetings" under the guise of CME or committee activity, mostly to get out of town to a pleasant vacation city for a few days away from the rat race. Not F.A.L. -- he went to the meetings and did his thing for the APA (while sending Jeannie to the nearest genealogical archives source in the area).

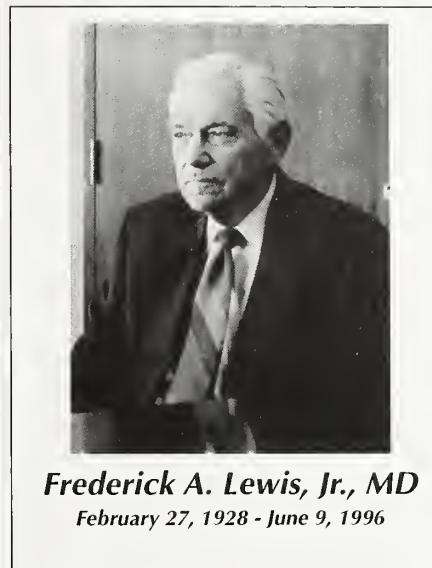
It might be proper to note here how Fred chose to enter psychiatry as his life's work -- he didn't choose, but rather was drafted into Uncle Sam's Army, and psychiatry was selected to him ('cause the Army thought it needed shrinks at that moment). I think Fred just said "What the Hell", and went on to spend a productive and rewarding career in that discipline which was thrust upon him by Uncle Sam.

Fred marched through literally all the chairs in organized medicine in Colorado, serving in various roles within hospitals where he practiced, waging the Denver Medical Society wars in untold councils, committees, task forces and the Board of Directors, and culminating his service to that organization as President, then Chairman of the Board.

Jayne Howard characterizes Fred as being "tenacious" in all his endeavors; I'm sure there are those among you who might choose a different descriptor -- stubborn, perhaps? Pick your own language, but it was never difficult to determine just where Doctor Lewis stood on any given issue, at any given time.

As a member of the Board of Directors, then President, of Colorado Medical Society, Fred had the mixed luck to be a part of an interesting era in that organization: during his tenure, CMS undertook a

rather complete rewrite of the Constitution and Bylaws (Who doesn't? It's a characteristic of medical societies to do that with each new administration!); they undertook the creation of a cockamamie creature to insure professional liability risks for the physicians of this state -- the creature which has now grown, from red figures on the balance sheet and borrowed capital for security, to become a thriving small business



Frederick A. Lewis, Jr., MD
February 27, 1928 - June 9, 1996

called Copic, with assets in excess of one-quarter billion dollars; and the final undertaking of that era in Fred's CMS tenure was the attempt at creating our own, private, palatial headquarters -- replete with Italian marble facade and waterfall feature in the entryway. Lest those of you who didn't live through that era think the "building fiasco" was of Fred's doing, rest assured that his was among the voices in the wilderness reminding us that doctors should not even attempt to don the garb of architect, general contractor, or the like -- but we didn't listen to those voices and almost destroyed the club in the process.

Rather than abandon his activity in CMS, Fred served in several recent years as Chairman of the Legislative Council, bringing to that process much needed patience, understanding, and the firm hand of leadership.

One thing perpetually noticeable in Fred Lewis was his warm relationship to the PhD-Psychologist community in Colorado: my interpretation of that warmth is that he'd just as soon see the whole lot of 'em burn in Hell -- but I'll leave that issue for you to determine.

Fred will be sorely missed at Copic, for he has been an integral part of its creation and growth throughout its history. As our "in-house psychiatrist" he played a vital role in each meeting of the claim committee for over fifteen years -- attending his final such meeting, in a wheelchair, just a few weeks ago. We will miss the wisdom and perspective he brought to that process.

He served long and well as Chairman of Copic's Finance and Investment Committee, bringing to that position greater knowledge of money and investment than most of Copic's docs, and a willingness to study and learn at a pace which served a young, growing company very well. The Finance Committee will never be the same as it has been for these past fifteen years.

These are but a few selected thoughts I have regarding this man we all loved, and who we have come here today to honor. I am deeply honored by Fred and his family and friends to be permitted to utter for the final public time: **"Fred Lewis, we love you."**

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Vision, Optimism, Tenacity, and Unwavering Commitment

Frederick Albert Lewis, Jr., MD
In Memoriam

Originally, this space was going to be occupied with an informational summary of the recent meeting of the Physician Insurers Association of America (PIAA), the trade association to which Copic belongs. But PIAA information will wait. I just came from a memorial tribute service for Fred Lewis, one of our founding Board members. Fred was planning to attend the PIAA meeting, but in spite of his relentless determination it was not to be. Fred's accomplishments will be remembered in these pages as well by his longtime friends, Bill Pierson and Mason Howard.

Instead of going to Fort Logan to be there when they put Fred to rest, I elected to try to put into print what Fred meant to Copic and therefore to all of you. The words in the title were some of those used at the memorial service to describe him. As each word was used, I could recall instances at Copic when Fred portrayed each attribute.

Fred was a member of the Colorado Medical Society's Executive Committee when the Society created Copic. The physicians of this state owe a great debt of gratitude to Fred and to his fellow physician visionaries and

career-long friends: Mason Howard, Amilu Rothhammer, Merlin Otteman and retired Board member David Bates. These visionaries saw an injustice and the need it created among their fellow physicians. The injustice was the commercial medical liability carriers' unwillingness to share information and investment profits. The need was for the product itself...a need which became acute in 1987 when these same carriers pulled out of the state when the going got tough. When reserves proved inadequate to absorb 1,200 physicians left without liability insurance, these visionaries — with the assistance of Tom Tucker, Copic's insurance consultant and yet another of Fred's friends — again found a way to meet the physicians' needs.

Yes, Fred was a visionary, but what he and his colleagues accomplished required more than vision. Fred also supplied the team with perennial optimism. As both of his physician sons attested at his service, his optimism about the practice of medicine not only brought them into medicine, but more importantly, has continued to be a beacon for them in these dark times of change.

Fred's optimism for medicine was undampened even as he dealt with his terminal cancer. He wanted and knew he could attend one more Claims Committee meeting and offer his insight. Fred did just that — oxygen tank and all. Fred obviously accepted his responsibility at Copic

with unwavering commitment.

The Copic Board, but especially the Claims and Finance committees, have lost a dedicated worker. We will miss Fred's intellectual analysis of the issues and his compassionate concern for his fellow physicians. His tenacity was without match. If an issue of principle, quality of work product, or especially a legislative concern was being contested, no one was more persistent in their effort than Fred Lewis (just ask Lorraine Koehn or Sandi Maloney). Fred demonstrated even more tenacity for life itself during his illness, and his courage and consistent dignity were a lesson to us all.

As the needs of practicing physicians change, the Copic that Fred Lewis helped to create has had to change as well. His vision for solutions has fostered and encouraged a near paradigm shift. We at Copic — and all practicing physicians — will need to maintain our dignity as the ever-advancing cancer of change attacks not just the system, but what seems to be us personally. The memory of Fred's optimism, tenacity, and unwavering efforts should provide inspiration for all of us.

Thank you, Fred Lewis, for being what you were. We will miss you dearly. We echo the words of Mason Howard: "We love you."



John Lightburn, MD
Historian
Colorado Medical Society

JOSEPH PROJECTUS MACHEBEUF, BUILDER OF HOSPITALS

The next two installments of the **Archives** will be concerned with the role of religious and charitable organizations in the health care of early Colorado. Here, we explore the work of Joseph Machebeuf, the first Bishop of Colorado, whose energy and vision resulted in the building of ten hospitals in the state. His leadership brought the dedicated sisters of four different religious orders to the state to build and staff those hospitals.

Joseph Projectus Machebeuf was born August 11, 1812 in the French village of Riom in the province of Auvergne, a province famous for its wines and cheeses. Auvergne was also known in the United States as a source for young priests who were recruited by the American Catholic Church to bring the church's teachings to the wild, rough and uncivilized frontiers of the new world.

Young Father Machebeuf and his fellow seminarian, Jean Baptiste Lamy, sailed in 1839 for New York where they were welcomed by many other French priests who had preceded them to the new world. He was assigned to a parish in Ohio where he became proficient in English and accustomed to the American way of life.

During this time, the United States went to war with Mexico. After defeating Mexico, America acquired vast new territory. This new frontier became fertile ground for development by adventurous pioneers, including the American Catholic Church. The church responded in 1850 by naming Machebeuf's old friend, Father Lamy, Vicar Apostolic of the New

Mexico and Arizona territories with headquarters in Santa Fe. Lamy recruited Father Machebeuf, and together they set out for Santa Fe. For ten years Machebeuf labored as Lamy's Vicar General, a prestigious title for a very difficult job.

Father Machebeuf traveled throughout the desert southwest in a mule drawn cart, a rolling church and rectory. This short, wiry Frenchman grew to love the desert, so different from his bucolic homeland. He often chose to sleep under the stars rather than in the cart.

In 1860 the Pikes Peak region came under Bishop Lamy's jurisdiction. A good man was needed for this new area. Reluctantly Bishop Lamy bid adieu to his old friend, and Father Machebeuf was sent to establish the new St. Mary's Parish in Denver. Thus Machebeuf came to Colorado where he was to leave a profound and lasting legacy.

Father Machebeuf started St. Mary's parish by obtaining donations of land from the Denver City Town Company and the Leavenworth and Pikes Peak Express Company. After taking the first steps toward establishing the new parish, Father Machebeuf became interested in the excitement in Central City. Both the economy and the population was booming there. He made several trips to Central City with his assistant Father Jean Baptiste Raversy to establish a church and also an "Invalid's House." The home was Machebeuf's first endeavor into the care of the medically ill. Unfortunately, after raising hundreds of dollars, their trusted fund raiser, James T. "Rascal" Ritchie dis-

"The good sisters had heard that up here on the world's mountain top was sickness, sorrow and despair, and they came to comfort."

—The Leadville Chronicle 1879

peared with the funds before the home could be built.

Sadder but wiser, Father Machebeuf joined others who turned their backs on Central City and refocused his energy on Denver. Fortunately for Denver, he found a more receptive environment. In 1864 and again in 1866, he asked Bishop Miege of Leavenworth to send a "colony" of the Sisters of Charity to start a hospital. After acquiring 90 acres near what is now Globeville, Father Machebeuf started work on the projected St. Vincent hospital. The project never progressed beyond the foundation being laid.

Despite these disappointments, he persisted and finally, in 1872, four sisters of Charity from Leavenworth arrived in Denver. On September 22, 1873, Sister Superior

ARCHIVES (Continued)

Joanna Brunner and Sisters Theodora McDonald, Veronica O'Hara and Mary Clare Bergen opened Denver's first private hospital at 1421 Arapahoe Street. With a very frugal budget, they served as nurse, housekeeper, cook and fundraiser. Their "hospital" soon filled, forcing them to live in the attic and to use the kitchen as an operating room.

True to their motto, "and the greatest of these is charity," they could turn no patient away. A year later they moved to a larger house at 26th and Market streets, only to



discover that their neighbors were the "nympha du pave" of Denver's red light district. When teasingly asked about their questionable neighborhood, Sister Joanna said she would take the question out of the neighborhood. One might have expected a sophisticated Frenchman like Father Machebeuf to have cautioned the good sisters about this move. In any event, after a short time on Market street, they moved again, this time into the Wentworth House at 1528 Curtis Street.

After these wanderings in the

"wilderness", Father Machebeuf and the sisters finally found a permanent home at 18th Avenue and Humboldt Street where they built an eighty bed hospital at a cost of \$40,000. They named the hospital St. Joseph's. From that modest beginning, St. Joseph's has grown with over ten major additions and expansions to one of the largest and most respected medical institutions in the state. Notable among the early supporters of the hospital were ex-governors William Gilpin and John Evans, Dennis Sheedy and Mrs. J. J. (the unsinkable Molly) Brown.

Not content with this accomplishment, the entrepreneurial Father Machebeuf (soon to be elevated to Bishop) and the hard working sisters expanded to Leadville where in 1879 they opened their second hospital, St. Vincent's. Miners paid a dollar a month to St. Vincent's to get full free health care at the hospital. (Amazing! Imagine managed care for a dollar a month; the program was possibly the first prepaid health insurance in the state.) The Leadville Chronicle, in a front page welcoming article wrote: "The good sisters had heard that up here on the world's mountain top was sickness, sorrow and despair, and they came to comfort...Many a rough, long bearded, coarsely appareled miner uncovered his head" at the sight of the sisters in their black and white habits.

In 1895, the same Sisters of Charity expanded to Grand Junction where they bought and operated St. Mary's Hospital.

Although the sisters from Leavenworth were the first to come to Denver and the first to build a hospital in Colorado, another Sisters of Charity with headquarters in Cincinnati had come to Trinidad in 1869. The first mission of the Sisters from Cincinnati was to establish the Holy Trinity School on land donated by Don Felipe Baca. Thirty years later, they opened Mt. San Rafael Hospital in Trinidad. The hospital served the community until the

county commissioners replaced the old stone structure with a larger, modern hospital which became nationally known for the work of one surgeon on the attending staff who specialized in gender change surgery (a procedure not envisioned by the founding sisters).

Before establishing their Trinidad hospital, the sisters from Cincinnati opened St. Mary's Hospital in Pueblo in 1882. Then in 1893 they assumed operation of the Albert Glockner Memorial Sanatorium in Colorado Springs, thereby fulfilling Bishop Machebeuf's original mission when he was sent by Bishop Lamy to minister to the early settlers of the Pikes Peak region.

Not content to rely only on the good work of the Sisters from Leavenworth and Cincinnati, Bishop Machebeuf welcomed yet another order. Four Sisters of Mercy came to Denver in 1882. Machebeuf asked them to open a storefront hospital in Conejos. After a few months, they moved on to the more substantial community of Durango to build Mercy Hospital.

Impressed with the work of the Sisters, on April 30, 1882 The Durango Times announced: "The Catholic Society . . . is just now completing a large, three story hospital . . . The Sisters of Mercy, that band of black robed and devoted women we have all learned to revere, have charge of the . . . building. Hereafter no poor helpless wanderer need die uncared for in a strange land, however friendless, moneyless or fallen."

Such wanderers who ended up in Ouray could also find care when the same sisters opened their St. Joseph's Hospital in 1887, which served the community until 1918.

As the mining camps boomed throughout the state, Denver prospered. The burgeoning Union Pacific Railroad needed a hospital for its employees. In 1886, with Father Machebeuf's help a small hospital was built at 40th Avenue and York Street. The Sisters of St. Francis from Olpe, Germany were recruited to staff the hospital later that year. In



Stately mansion in Salida, Colorado, converted in 1877 to the Denver & Rio Grande Railroad Hospital, the state's first industrial hospital.

Photo:Western History Section, Denver Public Library

1892, the sisters and the Union Pacific parted company. The sisters then opened their own hospital on the shores of Sloan's and Cooper's Lake. Far from the center of the city, they named it St. Anthony's Hospital.

Still seeking new opportunities to serve the community, Bishop Machebeuf asked the Sisters of Mercy to open a home for working girls in downtown Denver shortly before his death in 1889. After operating several different homes in the downtown area and losing one home in the panic of 1893, the sisters moved to 16th Avenue and Detroit Street. Later they closed the home for working girls to focus their efforts on building a hospital in Denver. By 1901, they dedicated their new hospital as the Mercy Sanitarium and Water Cure Institute. (What was the water cure?) With the completion of Mercy, the Machebeuf era came to an end.

Old records from the Colorado National Bank indicate that Bishop Machebeuf borrowed heavily to finance these many projects, at rates of interest ranging from 18 to 24 percent! Burdened by this enormous debt, he was almost constantly engaged in fund raising efforts. He moved among the wealthy of Denver and made trips to the industrial eastern states. This son of a French baker, educated in a little

known seminary in rural Auvergne France, with none of the formal organizational or marketing skills associated with a modern B. A., accomplished so much with so little. His legacy is enormous. When he

came to Colorado in 1860, he was alone with Father Raversy. When he died, the Diocese of Denver counted 64 priests, 102 churches, 9 academies, one college and 10 hospitals.

As the massive debt suggests, the hospitals were not "profit centers". Indeed, the few private for-profit hospitals that were built did not survive the economic ups and downs of the early part of this century. Dedicated, hard working and resourceful nuns administered and staffed the hospitals in pursuit of their mission of charity. It is interesting to note how different the modern for-profit hospital organizations (obligated to and supported by their stockholders) are from those that were created by pioneers like Father Machebeuf and the sisters. Progress is inevitable, with both benefits and costs. To repeat the motto of the Sisters of Leavenworth, "the greatest of these is charity."

Author's note: Thomas Noel's book, *Colorado Catholicism* and Dr. Robert Shikes' *Rocky Mountain Medicine* were the sources for the information in this article.

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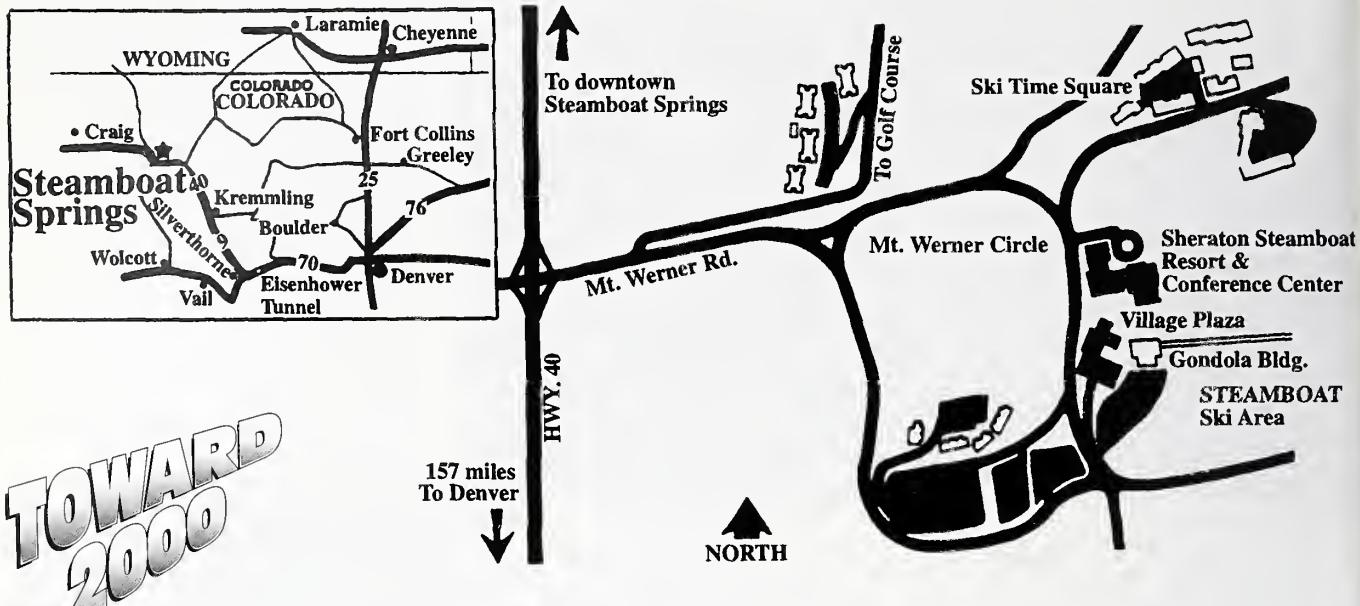
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Getting to Steamboat Springs



Colorado Medical Society Annual Meeting

September 19-22, 1996



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Leanne Kaiser Carlson, MSHA, to Keynote Annual Meeting



Leanne Kaiser Carlson, MSHA, an associate with Kaiser & Associates and a member of the International Health Futures Network, will be the keynote speaker at the 1996 Annual Meeting of the Colorado Medical Society. Ms. Carlson is recognized by hospitals and other healthcare organizations across the country for her state-of-the-art knowledge in health futures and the design of healthy communities.

Ms. Carlson will discuss how the flow of information is changing the face of the health care profession. She will explore how technological trends and future components will affect the individual practice of medicine, as well as physician organizations. Look for more details on this presentation, as well as the 1996 Educational Program "Towards 2000" in upcoming issues of *Colorado Medicine*.

CMS Annual Meeting Golf Tournament at the Sheraton Steamboat Golf Course Thursday, September 19, 1996 Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Steamboat I will be staying at _____
I will be attending the meeting in the capacity of (check one)

Physician

Exhibitor

Spouse

Other

I will: Sponsor a golf course hole @ \$100

Sponsor a putting green contest hole @ \$50

Name of sponsor (as you wish it to appear on sign)
(Professionally made signs will be displayed for sponsors.)

My golf handicap is _____
I will require rental clubs @ \$25

USGA
 Left handed

Other
 Right handed

If you would like to play please return this entry form as soon as possible because space is limited. CMS has reserved tee times for only eight foursomes. Play will be scramble format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$90 must be received **no later than** August 30, 1996. Cancellations received after August 30, 1996 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 879-1391.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

Annual Meeting Registration

1996 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 19-22, 1996, Sheraton Resort, Steamboat Springs, Colorado

Name (please print) _____

Component Society _____ Name of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1996. (Note: To attend the President's Dinner Dance on Saturday, you **must confirm** your tickets before noon, Friday, Sept. 20.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge.** Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 19

6:00 pm Welcome Reception member guest

FRIDAY, SEPTEMBER 20

7:00 am New Delegate Orientation Breakfast member guest

7:00 am AMA Delegation Forum Breakfast member guest

4:30 pm CMS Alliance Reception member guest

(for Alliance members & interested spouses)

5:30 pm Exhibitor Reception member guest

SATURDAY, SEPTEMBER 21

7:00 am Educational Program Continental Breakfast member guest

8:00 am Educational Program member guest

12:15 pm COMPAC Political Campaign Seminar member guest

7:00 pm President's Dinner Dance:

(Please select menu from below)

Beef and Chicken Dinner member guest

Vegetarian Dinner member guest

Vegan Dinner member guest

9:30 pm Copic Dessert Reception member guest

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast # _____ @ \$15 each = _____

President's Dinner Dance (Reservations necessary, please select menu below)

Beef and Chicken Dinner # _____ @ \$50 each = _____

Vegetarian Dinner # _____ @ \$50 each = _____

Vegan Dinner # _____ @ \$50 each = _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost

Number

FRIDAY, SEPTEMBER 19

12:15 pm COMPAC/CMSA Luncheon \$20 each

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).

COLORADO MEDICAL SOCIETY AND COLORADO MEDICAL SOCIETY ALLIANCE

Tentative 1996 Annual Meeting Schedule

Sheraton Resort and Conference Center, Steamboat Springs
September 19-22, 1996

THURSDAY, SEPT. 19

8:00 am- CMS Office open
9:00 am- 18-hole Golf Tournament
1:00 pm- 2:00 pm Finance Committee
2:00 pm- 5:00 pm Board of Directors
4:30 pm- 8:00 pm Registration open
6:00 pm- 7:30 pm Welcome Reception
7:30 pm- Dinner on your own

NOTE: Dress for Annual Meeting

Thursday evening reception any style from 1871 to present

Friday: casual

Saturday morning: casual

Saturday inaugural

dinner/dance: casual or "futuristic"

Sunday: casual

SATURDAY, SEPT. 21

7:00 am- CMS Office opens
7:00 am-11:00 am Registration
7:00 am-7:50 am Educational Program
7:00 am-11:00 am Continental Breakfast
8:00 am-12:00 N Exhibits open
9:00 am-11:00 am Educational Program
12:00 N- Alliance Meeting
12:15 pm-2:45 pm Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
1:00 pm-4:00 pm COMPAC Political Campaign Seminar (Lunch)
1:00 pm-4:00 pm Copic Seminar
6:00 pm-6:15 pm Army Natl Guard Physicians
6:15 pm-7:00 pm Cocktails - cash bar
7:00 pm-10:30 pm Inaugural
9:30 pm-11:00 pm Presidents' Dinner/Dance
Copic Dessert Reception

FRIDAY, SEPT. 20

7:00 am- CMS Office opens
7:00 am-4:00 pm Registration
7:00 am-7:45 am Reference Committee Breakfast
7:00 am-7:45 am New Delegate Orientation Brkfst
7:00 am-7:45 am AMA Delegation Forum Brkfst
8:00 am- 12:00 N Exhibits open
7:45 am-8:00 am Credentials Committee
8:00 am-8:30 am Opening Session House of Delegates
8:30 am-9:30 am Alliance Board
8:30 am-12:00 N General Membership Meeting
9:30 am-9:45 am Coffee break
9:45 am-11:45 am Alliance General Meeting
12:15 pm-1:45 pm COMPAC/CMSA Luncheon
2:00 pm-3:00 pm Alliance Workshop
2:00 pm-5:00 pm Army National Guard Physicians
2:15 pm-3:15 pm Copic Risk Management
2:15 pm-3:15 pm Copic Risk Management
2:30 pm-4:30 pm Reference Committee
3:00 pm-4:30 pm Alliance County Breakout Sessions
3:30 pm-5:30 pm Reference Committee
3:45 pm-4:45 pm Copic Risk Management
3:45 pm-4:45 pm Copic Risk Management
4:00 pm-7:00 pm Exhibits open
5:30 pm-7:00 pm Exhibitor Reception
6:30 pm-8:00 pm Women in Medicine Dinner and Business Meeting
6:30 pm-7:30 pm Colorado Society of Internal Medicine Annual Meeting
7:00 pm-9:00 pm Gone But Not Forgotten Dinner (by invitation only)

SUNDAY, SEPT. 22

6:30 am- Reference Committee Reports available
7:00 am- CMS Office opens
7:00 am-10:00 am Registration
7:00 am- 8:30 am Component Caucuses
8:00 am- 8:30 am Arapahoe
8:30 am-12:00 N Aurora-Adams
9:00 am-10:00 am Boulder
12:00 N (or immediately following HOD) Clear Creek Valley
12:00 N (or immediately following HOD) Denver
12:00 N (or immediately following HOD) El Paso
12:00 N (or immediately following HOD) Larimer/Weld
12:00 N (or immediately following HOD) Pueblo/Western Slope
8:00 am-8:30 am Credentials Committee
8:30 am-12:00 N Closing Session HOD
9:00 am-10:00 am CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD) Nominating Committee
12:00 N (or immediately following HOD) Reorganizational Board

**TOWARD
2000**

G oodbye Josephine - H ello 2000!

After all these years you would think someone would be standing around, shedding a tear or two with the departure of Josephine. Her service has been outstanding: she was dependable to a fault, required little in the way of cosmetics, did her job without complaint and only an occasional groan under the load.

What, then, led to the departure of Josephine under such belittling circumstances? You seldom have to hire someone to carry away a faithful staff member.

"Josephine" was the name given the "11/84 SN#KA01313 TU80 with RA81" mini-computer. (She was named by a female data systems manager.)



The "DEC PDP 11/84" (above left), and the tape drive (circa 1979) were outdated and were fully replaced on May 22, 1996, by a system server little larger than the monitor and keyboard atop the computer.



CMS Membership Information Services Director Tim Roberts gives the last of the outdated "mag-tapes" a frisbee toss into the dumpster, saying "So long, Josephine".

5-year replacement cycle of CMS computer system completed

Colorado Medical Society's planned 5-year replacement cycle was concluded on May 22, 1996. With this completion, CMS has now moved all its records and financial data onto a personal computer network, including 19 workstations and 4 servers. The new "DAT" digital storage tape cassettes, and networking have brought the Society's computer capabilities current. This will allow modular updating in the future, rather than having to replace the entire system. Installation of all new software to handle the membership data base was the final measure before closing down the PDP 11/84 system, in use since 1979. Included in the new system are Internet and World Wide Web capabilities, to be launched in the near future.

"Josephine" possessed all those traits mentioned above, plus a lot more. However, after 17 years of steady, seldom interrupted service, she was terribly outdated, and the change had to be made. There were a few of us who were here when "Josephine" was new to the organization, and we were awed and dismayed at the time by her prowess with printed words and number crunching.

Colorado Medical Society's Division of Information Services Director, Tim Roberts, commenting on all those years of service and her final days, could only say, "Well, we were lucky we didn't have to pay the company to haul her off".

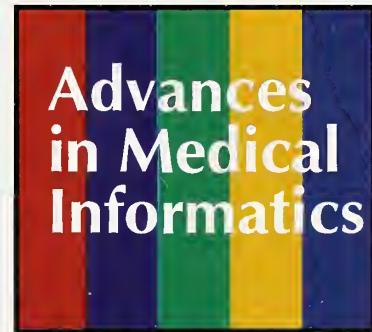


Division Director Tim Roberts uncouples CMS from another piece of past: a Teletype line printer. It went the way of "Josephine".

Information Security in the 21st Century



Michael S. Victoroff, MD, Chair,
CMS Medical Informatics Committee



As physicians move from 18th Century tools (pen and ink) to 21st Century tools (electronically stored medical records), we are discovering the new liabilities that attend our new capabilities.

Securing medical records in the paper age primarily meant filing your charts after scribbling on them, and keeping your office locked at night. (Actually the one endearing thing about handwritten notes is that they're relatively secure from prying eyes. Of course, they're also secure from the eyes of colleagues who wonder what they say.)

The security of medical records in the electronic age is a multifaceted problem. There are several distinct concepts embedded in the concept of "security." While the most basic of these issues is often overlooked, it is critical that physicians review their information security policies. Soon these security issues will not only be a problem for system engineers, they will also be a concern for every doctor.

- 1) **Reliability** – Does the system perform as expected? Does it retrieve what was put into it? Does it solve the problem it was built to address? Can a typical user make it work as intended?
- 2) **Integrity** – Is the data stable and consistent? (Is Mr. Figit's birthday the same date each time you look it up?) Are calculations and operations performed correctly? (Are there always 2.2 pounds in a kilogram?) Does the system resist accidental and intentional alteration? ("Whoops. The new nurse deleted Mrs. Filbert again.")
- 3) **Availability** – Is there protection

from unacceptable downtime? Is there a balance between log in restrictions and the need for convenient access?

- 4) **Survivability** – Does the system tolerate accidents? (Flood, fire, power outage, virus, spilled coffee, nuclear war?) What is the data backup plan?
- 5) **Safety** – Is the system safe for human use? ("Our new drug calculator just gave you 250 milligrams of digoxin. Sorry.") Is "competent Human Intervention" required? Must the system be merely "mission capable" or is it "mission critical?"

For most of us, information security deals with the trustworthiness of everyday transactions. How well does electronic data - a progress note, an insurance claim, a lab order, a pathology report - hold up against normal hazards? These include loss ("It was in here the other day..."); corruption ("It says here you're allergic to water..."); misattribution ("Dear Mr. Gibble, your pap smear was normal..."); wrongful disclosure ("All of us at work are saddened to hear of your recent impotence..."); misuse ("Let's see, that will be another 3,000 Percocet for Mr. Mork..."), etc.

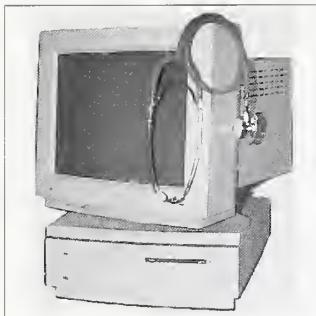
The National Institute of Standards and Technology identifies five major security services that apply to computer networks. (NIST Standard 7498-2.)

- 1) **Authentication** – Verifying the claimed identity of a user - or a computer itself. ("Please place the required part of your anatomy [e.g. finger, retina] against the scanner...")

- 2) **Access Control** – Determining and controlling the privileges of a user, after authentication. ("Sorry, you aren't authorized to breathe today. Please try again...")
- 3) **Data Integrity** – Assuring that the contents of a record (message, file, program) have not been altered without authorization. ("Our audit trail shows it was your auto mechanic who took out the \$5,000,000 policy on your life...")
- 4) **Data Confidentiality** – Protecting the content of records against unauthorized viewing and disclosure. ("Please press '1' to transmit your culture reports to CNN...")
- 5) **Nonrepudiation** – Protecting against false denial by a sender or recipient that a data item was sent or received. ("I realize that Mr. Hoover, but we clearly show you as the one who ordered these panty hose...")

Each of these concepts is worth a dissertation in itself. We'll explore more implications of computers in medicine during the year ahead.

Send comments and questions to informatics@cms.org.



Medicine in the Information Age: Follow that stethoscope!

by Chet Seward
CMS Communications

"The recent advances in medical informatics should not emasculate a physician's ability to practice medicine, instead they should empower the physician to provide even better care."

Walk into any doctor's office or hospital today and you will probably see a computer. Almost all of the administrative and financial services associated with the practice of medicine are now computerized. Yet many physicians are still struggling with the computer/telecommunications revolution. Some doctors are quick to note their deficiencies in administrative computer prowess because they concentrate on practicing medicine instead of practicing the business of medicine.

By downplaying the importance of automated administrative services, some physicians indirectly avoid the fact that amazing advances have also been made in computerized clinical services. Many doctors are wary of, if not intimidated by, those clinical advances because of the perceived threat they pose. Computers could prevent them from practicing what they went through countless years of medical school to do; physicians may fear that automated clinical systems will promote sterile interchanges of patient descriptions of symptoms and computer protocols that are divorced from any meaningful patient-physician interaction.

The following quote from a newspaper summarizes one doctor's recalcitrance. "That it will ever come into general use, notwithstanding its value, is extremely doubtful, because beneficial application requires much time and gives a good bit of trouble to both patient and practitioner. Because its hue and character are foreign to all our habits and applications."¹

Appropriate caution should be

exercised when it comes to technology that may disrupt the patient-physician covenant. However, that caution should not be confused with the skepticism that seems to consistently shadow technological change. The recent advances in medical informatics should not emasculate a physician's ability to practice medicine, instead they should empower the physician to provide even better care. Reluctance characterized in the quote above should not discolor the fact that technological advances have, and will continue to change the face of medicine – especially since the quote above came from *The London Times* in 1834 referring to the stethoscope.

The Institute of Medicine (IOM) recently surveyed 360 acute care hospitals around the nation to see if it was feasible to institute a computerized patient record by the year 2000. While the study provided some valuable information on how to improve patient records and communication, it also showed the degree to which computerization is *not* being used in the medical office. 95.6 percent of participants surveyed used computers for financial and administrative services. Despite advances in automating fundamental services in radiology, pathology and pharmacy, 91 percent of those surveyed have yet to computerize all clinical areas.²

Why is there such a distinct dichotomy between the use of computers in administrative and clinical services? Maybe it is because of the stethoscope syndrome described above, or maybe physi-

cians are waiting until more universal programs are created. Perhaps doctors invested their resources in earlier systems that are now defunct, or they are just hesitant to invest in modern information systems.

Whatever the case, the sweeping changes in information technology are affecting the way physicians practice medicine.

Over the past few months *Colorado Medicine* has attempted to pay particular attention to some of these issues. Hopefully you have noticed the new series called "Advances in Medical Informatics." The May issue of the magazine provides striking examples of how one member has implemented advanced computer systems to improve the quality of care (clinical

and administrative) in his practice. Other articles have highlighted electronic medical records, telemedicine and outcomes data. Further exploration of the advances in medical informatics is planned.

CMS needs your thoughts and suggestions about how the society can help members address these issues. On the back of this page is a survey on how the information age has affected you. Please take a moment to fill it out and mail it back to CMS. Your input will prove to be invaluable as the construction of the CMS home page and other projects progress. As always *Colorado Medicine* welcomes your feedback on these issues. Please write letters to the editor and tell us what you think.

Like it or not the information age

is here. The stethoscope syndrome and its aversion toward new technology must not continue. Perhaps one day computers in doctors' laps will feel as comfortable as the simple listening instruments they wear around their necks.

References:

1. David Pryor, MD. "Transforming Health Care Delivery Via Information Technology." A speech given to the Internet Virtual Conference entitled "The Emerging Health Information Infrastructure: Enabling Vision." Washington, D.C. April 15, 1996.
2. Furfaros, Carmen, Kristen Muchoney and Patti Anania-Firouzan. "CPR by the year 2000 - A Myth?" *Healthcare Informatics*. May 1996, p.47.

INTERNET

1

Riding the Information Highway

Colorado Medicine's how-to guide to the Internet

If the phrase "surf the net" provokes visions of long-haired beach bums playing in the ocean, then the following informational piece should bring you up to speed on certain aspects of the information superhighway. Browsing the Internet has become a national pastime, and physicians are quickly realizing the benefits of cyberspace communication. For those of you who have never taken "surf" lessons, or if your "net" skills need some polishing, here is a quick guide to the Internet.

Created originally in the 1960's as a means to reliably communicate in times of war, the Internet was the brainchild of a few prestigious universities, think tanks and the Pentagon. Today millions of people use online services like CompuServe or America Online to access the information superhighway. Using these services can be expensive. If you familiarize yourself with some key terms, then the time you spend on the Net can be more enjoyable and informative.

• **World Wide Web (www)** – is the

global web of information resources that combines text, graphics, sound and video. It can be accessed by a number of different software programs.

- **Electronic mail (e-mail)** – is just like the mail from the post office, except messages are transferred electronically and are stored in individually designated computer mailboxes. Messages can be sent via computer to one person or to a group of people.
- **Browsers** – are software tools that help you navigate the World Wide Web and other Internet resources.
- **Modem** – is your computer's connection to the outside world via telephone lines. Computers can "talk" with each other thanks to the modem.
- **Gopher** – is a popular menu driven search format used on the Internet. There are thousands of gophers on the Internet.
- **Network** – allows users to share information and other resources. It is a connection between two or more users. A connection of two or more networks creates an

internet (not to be confused with the **Internet** which is the world wide network of computers).

- **Listserv** – is the computer equivalent to a subscription service. Listservs allow individuals to communicate in real time with other users through electronic mailing lists.
- **Usenet** – acts as the electronic library for listservs. Usenets organize users' comments by topic (*newsgroups*) and posts them in central locations.
- **Hypertext** – is text that is usually underlined and allows users to link to other sites or files even if they are on different networks.
- **Home page** – is an organization's graphically designed "Web site" on the WWW. The home page gives a brief description of the organization. Work is currently being done on the CMS home page. Keep your eyes out for it in the coming months.

Medical Informatics Survey

The Colorado Medical Society is constantly striving to provide you with the most up to date information on how you can make your practice more efficient and enjoyable. Recent advances in technology have opened new avenues of communication for the profession of medicine. In an attempt to stay abreast of these developments, the Office Automation Task Force has been renamed. The new committee known as the Medical Informatics Committee (not to be confused with the old Medical Informatics Committee which was sunsetted in 1992) will explore current issues regarding medical informatics, as well as develop and editorially maintain the upcoming CMS web page. As the exploration of current issues and work on the web page progresses, the need for membership input has grown. We need to hear from you!

Please answer the following questions and return this survey to Medical Informatics Committee, CMS, P.O. Box 17550, Denver, CO 80217-0550. Or fax it to us at (303) 771-8657.

1) Would you like to know more about medical informatics and electronic data interchange?

Yes No

2) Do you use the Internet?

Yes No

If yes, what on-line services do you use most:

E-Mail News and education resources Other (please specify) _____

3) Is your office computerized?

Yes No

If yes, which services are automated:

Administrative (billing, scheduling, etc.)

Clinical (please specify) _____

Electronic Patient Record

Other (please specify) _____

4) If your answer to question number three was no, please elaborate why not:

5) What are your concerns about electronic data interchange?

6) What services would you like to see on the CMS web page?

7) Would you be interested in having an electronic copy of *Colorado Medicine* on the CMS web page?

Yes No

8) What issues would you like the Medical Informatics Committee to address next?

Thank you for your cooperation. Your input is valuable.

Name: _____

Address: _____

Phone Number: _____ E-mail address: _____

HEALTH CARE FINANCING



The Medicare Carrier, Blue Cross & Blue Shield of North Dakota, will be conducting **Part B** workshops throughout Colorado this summer. In addition to information on the **1500 form** and **ICD-9 coding**, the workshops will cover some of the more troublesome issues, such as the **Correct Coding Initiative, E&M coding** and the **Unprocessable Claims guidelines**.

To register, you must return the pre-printed enrollment form by approximately 10 days prior to the session you wish to attend. There is a charge of \$35 per attendee, to cover costs. The Carrier mailed the workshop forms in June. If you did not receive yours, you can call 831-1221 to obtain one.

Following is the schedule (please check your enrollment form for the complete location):

Day	Date	Time	Place
Wednesday	July 17	8:30-11:30 a.m. 1:00-4:00 p.m.	Greeley, Ramada Inn
Thursday	July 18	1:00-4:00 p.m.	Sterling, Ramada Inn
Wednesday	July 24	8:30-11:30 a.m.	Lamar, Best Western
Thursday	July 25	8:30-11:30 a.m. 1:00-4:00 p.m.	Pueblo, Holiday Inn
Wednesday	Aug. 21	8:30-11:30 a.m. 1:00-4:00 p.m.	Colorado Springs, Palmar House
Thursday	Aug. 22	8:30-11:30 a.m. 1:00-4:00 p.m.	Denver, Regency Inn
Wednesday	Aug. 28	1:00-4:00 p.m.	Craig, Holiday Inn
Thursday	Aug. 29	8:30-11:30 a.m. 1:00-4:00 p.m.	Grand Jct., St. Mary's Hospital
Wednesday	Sept. 11	1:00-4:00 p.m.	Alamosa, Best Western
Thursday	Sept. 12	8:30-11:30 a.m.	Durango, Holiday Inn
Friday	Sept. 13	8:30-11:30 a.m.	Cortez, Holiday Inn
Wednesday	Sept. 18	8:30-11:30 a.m. 1:00-4:00 p.m.	Denver, Regency Inn

If you have any questions, or need additional information, CMS members can contact Marilyn Rissmiller at (303) 779-5455 or 1-800-654-5455.



The **C**hoice Is *Theirs*

A video for physicians on Advance Medical Directives making End-of-Life Decisions

Are physicians well-informed and knowledgeable about Advance Medical Directives? Patients think they are, but some surveys indicate that many physicians don't know or understand current laws. *The Choice Is Theirs* video is specifically designed to walk the physician and his/her staff through the laws and their many features.

In an effort to assist the medical community and the public with questions on Advance Medical Directives, a consortium was formed. The goal of this group is to help educate all involved about these personal issues. The consortium includes: the Colorado Springs Osteopathic Foundation, Memorial Hospital, the Penrose-St. Francis Healthcare System, the Colorado Hospice Organization and Gonzaga University Television.

The Choice Is Theirs, a video about advance medical directives in the State of Colorado, (Living Wills, Medical Durable Power of Attorney and CPR Directives - Cardiopulmonary Resuscitation Directive) features Colorado and national experts from the legal, medical and medical ethic communities who answer the following questions:

1. What are advance medical directives as described in Colorado law?
2. What do these documents do for the patient and for the doctor?
3. When should advance directives be discussed with patients and families?
4. Who should have advance directives?
5. Where can the appropriate documents be obtained?

The Choice Is Theirs will be extremely helpful to the doctor, medical office staff, healthcare professionals, nursing educators, attorneys, and others. The video is a companion to "***The Choice Is Yours***", a video produced for the general public, patients and their families. The two videos complement each other, one directed to physicians and the other to the public/patient/families.

To order your copy of ***The Choice Is Theirs***, fill out the following order blank. Allow up to four weeks for delivery.

Name _____ Phone () _____

Address _____

Number of videos ordered _____ (\$25.00 each, including postage & handling) **Total \$** _____

MAKE CHECK OR MONEY ORDER PAYABLE TO: Colorado Springs Osteopathic Foundation (719) 635-9057
(MEMO: Advance Directive Video)

MAIL ORDER FORM AND PAYMENT TO:

The Choice Is Theirs (Video for Physicians)
Health Resource Center
The Penrose-St. Francis Healthcare System
P. O. Box 7021
Colorado Springs, Colorado 80933

Physician Profile Survey

Please let us know what you think!

By now most of you have received a copy of your physician profile. We hope you have made copies available for your patients. Please help us identify whether or not this project is useful by completing the following questions.

1) Are you participating in the physician profile project? Yes No

If no, please skip to question # 6

2) In which of the following ways do you make your profile available to your patients?

- copy on display in the waiting area
- copies left in waiting area for patients to take with them
- copies available upon request
- copies available upon request by patients only
- other

3) Have you attached your own addendum to your profile? Yes No

If so, what information have you included:

- additional office locations
- office hours
- additional professional training
- payment/billing information
- publications
- further explanations of information listed on profile
- other: _____

4) In general, have your patients found the information contained in your profile to be useful/informative?

- very useful
- useful
- not useful

5) Has the availability of your profile prompted enhanced communication between you and your patients?

- definitely enhanced communication
- slightly enhanced communication
- no change

6) If you are not participating in the physician profile project, please tell us why not.

- don't know about the project
- never received my profile
- currently awaiting revised profile
- do not think the profile is useful
- other

We value your input. Please provide us with any additional **comments/suggestions:**

Name: _____ Phone: _____ Specialty: _____

This project is open to all Colorado physicians. If you have not received your profile, please call Ellen Stein at 930-0414 or 1-800-654-5653. We are still working on revisions of some of the profiles that you have returned to us for correction. Those profiles should be back in your hands by mid to late July.

Thank you for completing this survey. Please return the survey to:

Colorado Medical Society
c/o Ellen Stein
P.O. Box 17550
Denver, CO 80217-0550

Volunteer Opportunities at the Hall of Life Exhibit!

The Hall of Life Health Education Center at the Denver Museum of Natural History is now accepting volunteer applications for their September 1996 exhibit training.

As a volunteer you will be part of a team to either provide visitor service, lead school tours, or interpret the exciting hands-on exhibits with the use of specimens and objects. Weekday, weekend and evening positions are available. Some positions available now.

If you are interested in becoming a vital part of health education, please call the Volunteer Office for more information.

Telephone (303) 370-6419.

**The Denver Museum of
Natural History
2001 Colorado Boulevard**

1996 Fall Clinics

Physicians from Colorado and several neighboring states will gather in Montrose to participate in the 25th Annual Montrose Fall Clinics on September 27 and 28, 1996. The Fall Clinics are sponsored by the Montrose Memorial Hospital and its medical staff. In recognition of their 25th anniversary, the "best of the best" speakers from the past 25 years have been invited to speak again at this year's Fall Clinics.

These guest speakers will present various medical topics during the meetings which will be held at the Montrose Pavilion, 1800 Pavilion Drive.

Registration will begin at 8:00 a.m. on Friday, September 27, with lectures throughout the day, and from 8:30 a.m. through 12:30 p.m. on Saturday, September 28.

Scheduled to speak at the clinic are:

- Walter G. Briney, M. D., Clinical Professor of Medicine, University of Colorado Health Sciences Center, Denver, Colorado
- Nancy J. V. Bohannon, M. D., Associate Clinical Professor, University of California, Private Practice of Endocrinology, San Francisco, California
- William DroegeMueller, M. D., Robert A. Ross Distinguished Professor of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, North Carolina
- John R. T. Reeves, M. D., Professor of Dermatology, University of Vermont, Burlington, Vermont
- Thomas N. Thomas, M.D., Private Practice, Forensic Psychiatrist, Maricopa County Superior Court, Phoenix, Arizona
- Lawrence L. Weed, M. D., Professor of Medicine Emeritus, College of Medicine University of Vermont, Burlington, Vermont

Topics discussed at the Clinic will be:

"Osteoporosis: How to Evaluate, How to Diagnose; How to Treat";
"New Treatment Options in Rheumatology";
"New Treatment for Diabetes";
"Secondary Prevention of Coronary Artery Disease";
"Vaginitis";
"Physician Burnout";
"Cocktail Party Dermatology";
"Dermatology Treatment Pearls";
"Knowledge Coupling: New Premises and Tools for Medical Care and Education";
"Vincent VanGogh: Mind, Madness and Medicine".

Interesting case presentations will be discussed at the end of Saturday's program by the participants as well as the guest speakers.

In addition to the medical lectures, participants will have the opportunity to visit over 50 pharmaceutical displays by various drug companies. These provide the physicians the opportunity to discuss new products and techniques with the company representatives.

Eleven hours of Category I AMA credit will be given to those attending the Clinic.

The Annual Fall Clinics Awards Banquet and dance will also be held at the Pavilion on Friday evening. Music will be provided by Swingtime in the Rockies. The post conference retreat on Saturday will be held at the Dickinsons at Telluride Ski Ranches in Telluride, Colorado.

Persons who would like further information on the clinic may contact Kathy Holman at the hospital, 303-240-7397.



Credit card medicine

by Chet P. Seward
CMS Communications

"Paying for medical services with a credit card is becoming less of an innovation and more of a patient expectation."

Swoosh. . . ching, ching! The sound of yet another person purchasing something, somewhere on their credit card. Using credit has become more than a means of carrying less cash or stretching constricted budgets. Now it is a way to receive consumer bonuses like frequent flyer miles and extended warranties. You can pay for just about anything these days with your credit card — groceries, electric bills, automobiles and even health care. What does this push for more plastic signal for physicians and their practices? As a doctor, what can you expect from your patients with regard to credit cards?

A recent Visa USA Consumer HealthCare Study, which focused on methods of payments for out-of-pocket health care expenses, found that nearly one-third (29 percent) of consumer respondents say their out-of-pocket health care costs have increased over the past year and more than one-fifth (21 percent) say their insurance deductibles have grown.

The increased presence of managed care in the market place and stricter reimbursement for care from employers and insurance companies help account for this rise in health care co-payments. As a result, the consumer must pick up a larger part of the tab for medical services. The Visa survey noted that while 89 percent of those surveyed had health insurance, 71 percent of the respondents have not saved or put aside money for out-of-pocket health care expenses.

Providers offer a number of different options (installment plans, credit cards and deferred payments)

to their patients to pay for routine and unplanned care. Paying for medical services with a credit card is becoming less of an innovation and more of a patient expectation.

Credit cards can facilitate payment of medical services, but there is a price for flexibility. *Medical Economics* recently reported that delinquent credit card bills have reached a three year high. Everytime a patient pays a medical bill with a credit card, a specified portion of every transaction goes to the credit card company. Fraud and other administrative problems associated with instituting and maintaining the program also deter some physicians from utilizing such services.

Visa USA recently introduced a new interactive diskette that demonstrates proven techniques for improving collection of patient payments with the Visa card. The diskette, which is available in Macintosh or PC/Windows versions, highlights various Visa tools like office staff training videos, educational materials, office signage and consent forms. Such tools may prove to be important in the years to come as physicians struggle to preserve their fair share of the health care dollar.

The credit card boom is alive and well, given the fact that the Visa card is accepted for payment of health care services by 95 percent of hospitals, 51 percent of physicians and 80 percent of dental offices. Visa transactions in the health care industry in 1995 reached \$6.6 billion (a 34 percent increase over 1994). Perhaps it is time for you to review the pros and cons of credit cards, as a service to your patients and to your practice.

For more information on the Visa Approach to Collecting Patient Payment interactive diskette please call 1-800-461-8472. Or call the CMS Communications Dept. at (303) 779-5455 or 1-800-654-5653.



New cyberspace resources for physicians and patients

The information superhighway continues to speed physicians and patients tools for better health care. The newest additions include the Colorado based cyber magazine, *The Medical Reporter*, and a web site for primary care physicians.

The Medical Reporter is a monthly educational health magazine on the World Wide Web for enlightened health care consumers. Published solely in cyberspace since April of 1995, *The Medical Reporter* emphasizes preventive medicine, primary care, patient advocacy, education and support, as well as topics in subspecialty medicine of interest to men and women.

The Medical Reporter can be accessed at: <http://www.dash.com/netro/nwx/tmr/tmr.html>. In addition, the journal provides a comprehensive directory of related Web sites to which it is linked (or on which it is carried), so that readers can easily find their way to many excellent sources of health and medical information on the Web. *The Medical Reporter* is listed with YAHOO! and GNN (Global Network Navigator).

Resources for Primary Care Physicians is a web site designed especially for family physicians, general internists and general practitioners. The site includes the popular Directory of Consulting Sub-Specialists (sub-specialists who have agreed to consult with, or answer questions from, primary care physicians by Internet e-mail). The site also features a variety of timely news

articles and information suitable for patient education purposes quickly and easily on the Web. Access to the site is free. Go to: Resources for Primary Care Physicians at <http://www.coolware.com/health/pcp/pcphome.html>. Or call (303) 337-6299.

Case study book on medical ethics

Ethical Choices: Case Studies for Medical Practice, published by the American College of Physicians (ACP), uses real-life situations to show how the principles of medical ethics apply to physicians' daily practices and patients' health, welfare and rights.

This "ethics manual," now in its third edition, is a widely cited and respected code of ethics for physicians. "Many ethics texts stimulate discussion of ethics, but the cases in this book are directed toward stimulating thought and action," says Lois Snyder, JD, ACP's counsel for ethics and legal affairs and editor of the book.

Among the topics addressed are: fee for service vs. managed care; physician/patient sexual relationships; disclosure of errors and threat of malpractice; patient prejudice and referrals and; disagreements between residents and attendings.

The book can be purchased from the American College of Physicians for \$33 (\$25 for ACP members), by calling ACP Customer Service at 1-800-523-1546, ext. 2600.

New MRI technology helps detect breast cancer

A new form of magnetic resonance imaging (MRI) can detect lobular carcinoma, a highly malignant breast cancer, which is not easily detectable by mammography or a physical exam.

The new form of MRI, three-dimensional rotating delivery excitation off-resonance magnetic resonance imaging (3-D RODEO MRI), provides 20 times higher resolution and much better contrast than conventional MRI, according to the recent study presented by Dr. George N. Rodenko, from the MRI Department at Baylor University Center in Dallas, TX.

In the study, RODEO MRI was used to detect lobular carcinoma. RODEO MRI's finding agreed with the pathology results in 85 percent of the cases while mammography only accurately predicted the extent of the cancer in 31 percent of the cases.

About one third of the cancers are found in both breasts and many cases spread to more than one area of the breast. Since the spread of the cancer cannot be accurately predicted by mammography or conventional MRI, mastectomies tend to be performed in all cases of lobular carcinoma. However, RODEO MRI can predict the extent of the cancer, making breast-conserving treatment (lumpectomy combined with radiation therapy) an option for some women.



Survey shows top ten employment markets for physicians

Recent gloom and doom physician employment predictions may be wrong. A national survey by the physician recruitment consultants at Merrit, Hawkins & Associates found that over 70 percent of the nation's hospitals are recruiting physicians, as are over 60 percent of larger medical group practices.

The survey also identifies the top ten employment markets for physicians – areas where physician recruitment in a variety of medical specialties is particularly aggressive. These markets include: Eastern Washington State; Evansville, Indiana; Fargo, North Dakota; Mississippi Gulf Coast; North Central Florida/Panhandle; Northwest Arkansas; Quad Cities, Iowa; Springfield, Missouri and; West Texas.

Merrit, Hawkins & Associates' president, James Merritt, noted, "What's clear is that while managed care is driving physicians out of some markets, jobs are still available in other markets traditionally underserved by physicians...The problem is still one of maldistribution rather than oversupply." Merritt concedes that the majority of hospitals and medical groups recruiting physicians are seeking primary care practitioners. However, he does not agree with some experts who believe that tens of thousands of medical specialist will be driven out of medicine by managed care.

Hepatitis B immunizations now mandatory

The Colorado State Board of Health has voted to add hepatitis B to the list of immunizations Colorado children are required to have before they enter kindergarten and the seventh grade. The hepatitis B virus can cause liver disease and cancer.

The new requirement will become effective in September 1997 with the beginning of the school year. Hepatitis B shots have now been added to the list of required immunizations which include diphtheria, Haemophilus influenza type B, measles, mumps, pertussis, polio, rubella and tetanus.

Gerrit Bakker, an epidemiologist who is in charge of the State Health Department's hepatitis B project,

said, "These immunizations have proven to be safe, effective and low-cost measures that will protect people from hepatitis B for the rest of their lives."

According to Bakker, the vaccine will be provided free in Colorado to Medicaid-enrolled children and to children from families who do not have health insurance or are underinsured. The vaccine will be provided by the federal Vaccines for Children Program and distributed by the State Health Department to public health clinics and private physicians throughout the state.

Most health insurance companies are expected to provide the shots to the children of their policy holders as part of their regular benefit packages.

Women in Medicine Leadership Conference a success

The Women in Medicine Section (WIM) of the Colorado Medical Society had an empowering Leadership Conference on April 20, 1996.

WIM provides a means for women physicians to network and participate in organized medicine. Keynote speaker Linda Hawes-Clever, MD, kicked off the conference with an inspirational speech. Current WIM president Deborah K. Bublitz, MD commended Dr. Clever for emphasizing the need for women physicians to uphold the basic tenets of the profession and transcend some of the destructiveness which is encroaching on it.

"(Dr. Clever) challenged us to be participants in our own destinies and in so doing, to take good care of ourselves as well," said Dr. Bublitz.



Dr. Clever speaks at the WIM Conference.

Other topics discussed include medical marriages and the impact children have on careers.

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

Society has talked a lot about good versus ill which television can do/has done. Early on, we admitted it was the most powerful medium ever devised, one that could do great educational things not even yet envisioned.

We've also voiced our fears and frustrations with TV in later years, decrying its use as a robotic baby-sitter, a catchall for every social ill we could imagine, and we still believe that it (television programming) is a vast wasteland.

But now, I believe we have reached the moment in time when the television ogre will be replaced by an even greater social force. We don't fully recognize the number of ways it is affecting our human relations. This new medium is a little like alcohol consumption or tobacco use; socially, it is accepted because its ill effects can be hidden.... until someone sits down and starts closely analyzing and pointing the finger.

The **new ogre** is the **computer**! We accept it because it is a large force in the work place. We accept it because so much of our entertainment resides in "chips." We accept it as a part of a new social order because that is exactly what it is: a major part of a new social order. The problem I see with this acceptance is that, underneath, the computer is changing us all into something I don't like: invidious, basically repugnant people who care nothing about our fellow persons and are much too engrossed in recently-acquired behavior that we resent all regulations, laws, or social order.

We are becoming a society which expects everything to be delivered at as high a speed as

possible. If forced to pause, to wait, to limit, to acknowledge, to accede, then we become resentful and acrimonious. These distasteful traits are demonstrated by all ages, in all variety of circumstances, and there is no sexual discrimination:

- Driver of a car, operating far beyond the posted speed limit, is resentful when another vehicle (yours) merges into the flow, but at something less than what he/she is traveling. The "offending" driver is very likely to receive some profane gesture as the other car swerves around you, probably cutting off three other lanes of traffic to do so.
- Five-year-old child seems uncontrollable when having to wait for fulfillment of some demand he/she has made to the parent. Many children are no longer accustomed to waiting or required to do so.
- Office worker who hurried to get to work and put several people in other vehicles at serious risk (and was still several minutes late), can now **not** wait the required **3 to 5 seconds** for the computer to complete the multimillion calculations you just demanded of it with only the touch of a key.

It's additionally frustrating when the Manager says that if the office had the budget, he could buy a driver upgrade that is 8 times faster than the present one. And there **this person** sits, having to wait 5 seconds while the "junker" mills and dithers. If this same office person has to wait from 2 to 15 minutes for the computer to complete a task, the person is absolutely lost because there is no task that can be started which would effectively use the time.

How does this affect our sociometry?

When this same office person gets into the car at the end of the day (probably to go home to push another button and bring dinner to the table), the person takes out these frustrations on other drivers through the operation of his/her vehicle: it doesn't take a budget increase to make this machine go 8X faster, dart more quickly, reach 75 m.p.h. in 0 to 7 seconds. No, this person feels completely in control, for the first time since going to bed last night. Now, they can show man and machine that they have it all, not bound by rules, regulations, laws, considerations, or personal identity. They'll be long gone before anyone can identify them. If they do get caught in the bright light of public scrutiny (when they absolutely can't escape stopping in the lane next to you for a traffic signal) they slide low in their seat, holding their cigarette by the slightly-opened window (to show their environmental concerns), once in a while looking to either side. If they catch your eye, they're glaring or at least frowning in your general direction. They are quite apparent in their desire not to be bothered: **Stay out of their space; hands off their chip!**

We are raising our next generation this way, from the ground up. Remember, everyone has computers; it isn't just a chosen few that are affected. From the computer games to the high-tech office, to the giant earth-mover, to the buildings in which we live and work... everything is computerized. Might's well get used to it. We're changing.... and not for the better!



Joel M. Karlin, MD
President, 1995-1996



While musing over an early morning cup of coffee, I concluded that the evolution of managed care has provided a valuable lesson. Its primary objectives are noble: minimize total cost per patient per year; maximize quality and; maximize patient services. Unfortunately, to date no model or system has truly achieved all of those objectives. Moreover, as systems have evolved other important issues like professional in-fighting have brewed to boiling levels, and as a result patient care has suffered. Non-physician interests have used the strategy of divide and conquer in pitting primary care physicians (PCP) and specialty care physicians (SCP) against each other. The question now is how do we move beyond these internal struggles to continue to provide cost effective, quality care?

Historical underpinnings, like earnings differentials, payment inequities for cognitive and procedural services, perception of "elitist" attitudes and patient referral behaviors, were easy targets for the exploitation of the schism between PCPs and SCPs. Certain managed care systems employed coy techniques, such as profiling PCP referrals to SCPs, financially rewarding PCPs for not referring to SCPs and redistributing unspent SCP pools to PCPs, to drive a wedge further between the two groups.

Undeniably the damage is done and the profession of medicine is now at a critical juncture. A solution must be found to meet both the objectives of "good" managed care and to diffuse the internal strife that threatens the collegiality of medi-

cine. Fortunately there is hope. Physicians are no longer running scared from managed care. Instead they are learning how systems and models work, and they are cooperatively acting to ensure that the best possible care is provided in those systems. I propose that the answer will be found in the next generation of managed care.

Before a discussion about the next generation of managed care can begin it is important to remember a few facts about health care expenditures that are not common knowledge. First, in a normal under 65 population, 30 health conditions account for 80 percent of the cost. Second, 9.8 percent of all Medicare beneficiaries (most of whom have chronic conditions) account for 68.4 percent of all Medicare expenditures.

Given those facts, I believe that certain attributes of current managed care systems will fail. Unrestricted access to specialty care services without accountability and "king of the hill" primary care systems will not evolve with the next generation of managed care. In the future, PCPs and SCPs will work together to provide a continuum of care for specific clinical entities. While such a vision may seem a bit sour to swallow now, successful models already exist that can be used as case studies for future reform.

The Vermont Program for Quality in Health Care is a private, non-profit corporation dedicated to improving the quality and efficiency of Vermont's health care system. Their Board includes representation from the Vermont Medical Society,

(Continued next page)

"...the evolution of managed care has provided a valuable lesson."

(President's Letter cont.)

insurers, hospitals, nurses, Vermont Data Council, State Health Department, employers and the state legislature. They work through study groups which include both PCPs and SCPs investigating difficult clinical problems. By reviewing its first two disease entities, carpal tunnel syndrome and otitis media, the program produced practice guidelines, referral guidelines and treatment algorithms.

The physician controlled Lovelace Clinic is an integrated delivery system based in New Mexico which seeks to provide better methods of containing costs, while maintaining or enhancing quality. In 1993, they entered into a new program designed to provide a more comprehensive, system-orientated framework to improve

clinical practice for given disease entities across the entire continuum of care, emphasizing costly, complex diseases. The program, Episodes of Care, brought together both PCPs and SCPs to look at what was being done in both the inpatient and outpatient settings. The first nine conditions selected accounted for 24 percent of their total health care costs. They included: diabetes, pediatric asthma, coronary artery disease, pregnancy/birth, low back pain, breast cancer, stroke, depression and knee care. Their objective is to integrate a number of diverse functions into one clinical practice improvement umbrella (care maps, guidelines, utilization management and outcome measure). Each team consists of PCP and SCP as co-chair, with full support personnel, including nurse case managers, specialists for physician and patient education,

quality measurement specialist and other clinicians. The interaction of PCP and SCP is designed to foster the standardization on a disease-specific basis of levels of care to be provided by PCPs and SCPs. Practice guidelines specify the points at which the patient should be referred from PCP to SCP, and from SCP back to PCP.

The Vermont program and the Lovelace Clinic are concrete examples that demonstrate that physicians can move beyond internal strife to practice cost-effective, quality medicine. Managed care has provided a good lesson, and it is up to our profession to cooperate to provide the most appropriate care in the most appropriate clinical setting. In the end, health plans which foster this cooperation will rise to the top, those that don't will fail.

LEGAL UPDATE

The American Jury

Has the American jury outlived its usefulness? Has this bastion of justice become so riddled with weakness and so manipulated by its lawyer tenders that it is no longer viable? The O.J. Simpson trial, the McDonalds case and other products of our legal system have left our society in doubt about its ability to function effectively.

Positions have been taken on both sides of the issue. Consumer advocates claim tort reformers are using anecdotal information to panic the citizenry. The press is supplying the public with just enough information to prompt inaccurate conclusions. What the public was not told is that the McDonalds case settled for a paltry sum in comparison with the original verdict and McDonalds has now agreed to reduce the temperature of its coffee to a level commensurate with other fast food operations in this country. Statistics demonstrate there has not been a litigation explosion in this country, nor has there been a flood of outrageously high jury verdicts. Punitive damage awards resulting from

product liability actions are few and far between. Tort reform measures passed over the years have not produced the desired results (e.g., auto insurance has failed to contain premium costs; medical malpractice statute limitations have not controlled physician insurance premiums or health care costs).

So who is right? We know one thing – criticism of our legal system is not new. In 1911, Moorfield Storey, a former president of the American Bar Association, warned Yale Law School students that civil actions for damages were choking the courts. Storey predicted such suits were increasing at a rate entirely out of proportion to the increase of the population.

At the end of the 1880's, Justice Oliver Wendell Holmes, while still on the Massachusetts Supreme Judicial Court, expressed a similar concern. "I think," he wrote an English friend, "There is a growing disbelief in the jury as an instrument for the discovery of truth." Justice Holmes recognized that although jurors swear solemnly to decide the matters before them entirely on the evidence

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presented and the legal rules as the judge explains them, they regularly reach verdicts that disregard evidence, law or both. Today we call this phenomenon "jury nullification" and regard it as either laudable or deplorable, depending on our sympathy with a particular result.

Does the level of recent concern mean that we should eliminate the jury's role as a primary fact finder in our system of justice? The answer, of course, must depend on what might replace jurors in administering justice. Perhaps the jury, to paraphrase what Churchill once said of democracy, is the worst mechanism for trying cases except for any alternative. Perhaps the only thing wrong with juries is that they are human.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000



A glimpse of our galaxy.

The bottom line is, you gotta come in and hear our systems for yourself. Get lost

in the big screens. Feel the thunderous bass



come right through your feet. These are just a few



Reference Theatre Room.

Barco Data Grade rear projection video screen,
Snell Cinema/Music reference speakers and Krell electronics.
Systems from \$15,000-\$100,000.

snapshots of what you'll begin to see and

hear and feel once you're in our universe.

Architectural Electronics Room.
In-wall or in-ceiling speakers, weatherproof speakers,
digital telephone/intercom systems
and low-voltage lighting. Systems from \$200.

The THX Room, as photographed on



the opposite side, features a Runco Cinemapro

Reference Audio Room.

Featuring the premier lines of Krell, Thiel and Avalon.
Audio systems that will change the way you hear music.
For life. Systems from \$2,000-\$50,000.

video projector, a Lucasfilm THX home theatre audio system, Boston Acoustics

THX speakers, Marantz electronics and custom cabinetry. Systems from \$2,500

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SOUNDINGS
It's that good.



Did you know there is
an alternate universe?



One of the new home theatre rooms at Soundings. Quality systems from \$2,500.

We're not talking science fiction here. The reality is, you don't have to shop for a stereo or home theatre system at a superstore, or a gigastore, or a megastore to find exactly what's right for you at the very best price. When you come in to Soundings you'll be greeted by our receptionist and matched with a real-live human expert in audio or home theatre. We'll take you on a journey of Good, Better, Best, according to your budget. Eight different rooms of systems ranging from \$2,500 to over \$100,000 allow you to compare what's available in your price range. Sure, we customize ultimate systems, complete with hand-crafted cabinetry and dramatic mood lighting. Yet even our moderately-priced components will send you to the outer limits, unlike those "superstore" rack systems. Ours is a smaller universe. But that's what happens when you eliminate all the mediocrity. Corner of Evans & I-25. 759-5505. 7 days a week.

SOUNDINGS
It's that good.

CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

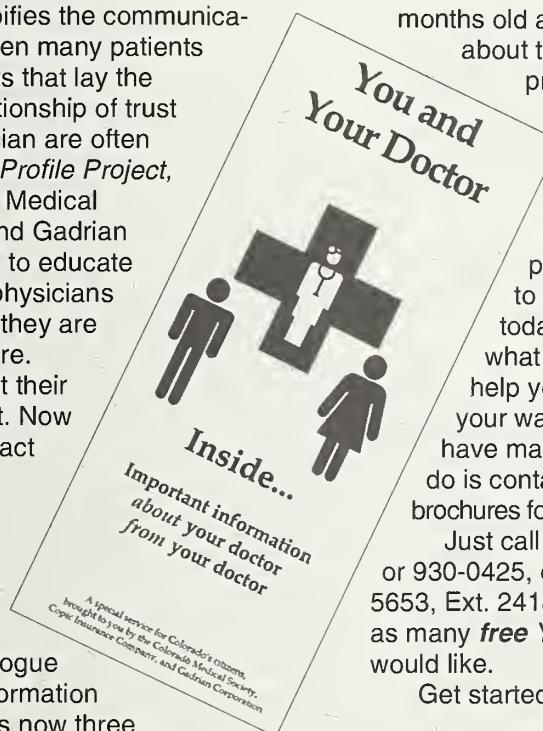
AT PRESS TIME...

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

"My doctor is a what?"...Do your patients know the facts?

The question above typifies the communication that exists today between many patients and physicians. Simple facts that lay the foundation for a sound relationship of trust between patient and physician are often overlooked. The *Physician Profile Project*, sponsored by the Colorado Medical Society, Copic Insurance and Gadian Corporation, has attempted to educate the public about Colorado physicians and reassure patients that they are getting the best possible care. Today, patient doubts about their physicians are ever present. Now is the time to reinforce the fact that you are your patient's advocate, and you are dedicated to providing quality care.

The *Physician Profile Project* has been a great success in facilitating a dialogue about physician specific information with patients; the program is now three



months old and many physicians are encouraged about the results. An important element of this project is the distribution to your patients an informative brochure telling the patient how he/she can obtain more information about a doctor of their choice. *You and Your Doctor* provides an opportunity for you to talk with patients and potential patients in an effort to raise the public comfort level about today's practicing physicians. After all, this is what the public is demanding; help them and help yourself by distributing these brochures in your waiting room. CMS, Copic and Gadian have made the project a reality. All you have to do is contact CMS offices and we'll send you brochures for your own waiting room - no cost to you.

Just call CMS Communications, (303) 930-0418 or 930-0425, or (outside Denver area) 1-800-654-5653, Ext. 2418 or 2425. We will be happy to send you as many *free You and Your Doctor* brochures as you would like.

Get started NOW! Call as soon as you can.

Candidates for President-Elect – Annual Meeting 1996



Thomas J. Allen, MD, is the current president of the Larimer County Medical Society. Specializing family practice and occupational medicine, Dr. Allen is on the CMS Board of Directors and the Colorado Physician Network Board of Directors. He is a member of the CMS Executive Committee and the Council on Legislation. He is a legislative key contact and Chair of the CMS Health Systems Reform Task Force. Dr. Allen received his medical degree from Indiana University.



Gary D. VanderArk, MD, is an Arapahoe Medical Society Delegate to the CMS House of Delegates. A neurological surgeon and former president of the Arapahoe Medical Society, Dr. VanderArk, is a legislative key contact and the founder of the "Doctor's Care" program. A prior member of the CMS Board of Directors, he was the recipient of the AH Robins Community Service Award in 1990. Dr. VanderArk received his medical degree from the University of Michigan.

Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm
of Montgomery Little & McGrew, P.C.

This column contains information concerning topics
of general interest in the medical-legal field. For further
information or help with specific problems, please
contact Montgomery Little & McGrew, P.C.

A few questions you always wanted to ask, but didn't for fear of incurring legal fees

Q: During the past year I haven't dictated detailed office notes for patient visits. I have some notes scribbled down on scraps of paper in each patient's chart. If an attorney asks for a copy of a patient's chart that's missing dictation, what should I do?

A: Provide a copy of the patient's office chart, as is. If asked later, you can prepare a detailed report or speak with the attorney about the specifics of your visits with the patient. Do not "complete" the patient's chart by back-dating dictation or filling in detailed notes, then throwing away the scraps of paper. Any note should bear the date of preparation. Avoid even the appearance of altering the medical record. From a legal standpoint, the accuracy of a note prepared long after care is provided is questionable on the grounds that memory fades over time; the accuracy of a note generated after an attorney asks for the chart is downright suspicious. Notes dictated after an untoward event, such as a bad result or the death of a patient, often tend to be self-serving and defensive.

Q: If one of my cardiac patients signs a form permitting me to send a copy of her medical records to an attorney, and the records contain information about the patient's hospitalization years earlier for treatment of bipolar disorder, do I have to send the records?

A: Information concerning a patient's mental, emotional and psychiatric condition enjoys a more restrictive privilege than records concerning the patient's physical condition (with certain exceptions). If the authorization for the release of records does not specify that it extends to records pertaining to the patient's mental, emotional and psychiatric condition, those records, or that portion of the record, should not be sent to the attorney.

Q: How long should I keep medical records?

A: Colorado has no law requiring physicians to retain medical records for a certain period of time. Some other states require retention for seven years. From a malpractice defense perspective, records should be retained until the statute of limitations has expired. Unfortunately, in some cases (as for incapacitated people) the statute of limitations never expires; for others, the limitation period does not begin to run until the patient "discovers" the physician's negligence and its causal link to the patient's injury. This can take years, and is unpredictable. Different liability carriers have developed recommendations for their insureds. For example, one carrier recommends keeping medical records ten years after the last adult visit, 28 years from birth for all minor patients or five years after death.

Q: My group will be interviewing applicants for a receptionist position. We need someone who we can rely on to be there every day. Can we ask the applicants about their health?

A: No, not during the initial interview. The Americans With Disabilities Act (ADA) prohibits discrimination in hiring based upon an applicant's disability. To avoid actual and apparent discrimination, the interview process must focus on the applicant's qualifications to perform the functions inherent to the position. If an applicant is qualified for and is offered a position, you may then ask whether he or she has any illness or condition which would interfere with his or her ability to perform the job. Not all illnesses and conditions are considered "disabilities" under federal law warranting protection. If the employee discloses a "disability," the employer must consider whether reasonable accommodations can be made which would allow the individual to perform the job, despite the disability. Reneging on a job offer on the basis of a disability which can be reasonably accommodated violates the ADA and subjects the violator to severe penalties.

Q: Can I be held liable for a "curbside consult?"

A: It depends. If the contact with your professional colleague about the patient is strictly informal, if there is only one contact and not a series of contacts, if you have no direct contact with the patient, if you do not prescribe any medications or order any tests or studies and if the patient is being cared for by another physician for that condition, then you probably would not be held liable for anything you said during that type of informal consultation. This is not to say you couldn't be sued if an unfortunate outcome occurs and the patient finds out what you recommended or concluded during the curbside consult. If you speak with the patient, if you give the patient any medical advice, if you prescribe a medication or order a test or study, you have crossed the boundary and entered into a physician-patient relationship, for which you may be held liable.

CMS Med Fax

Colorado Physicians conference to analyze managed care

"Managing Managed Care 1996" is the featured fall program for the Colorado Physicians conference. The conference, to be held on October 5, 1996, is designed to help physicians face the fast and furious pace of managed care. Focusing on strategic planning techniques, its content will provide a better understanding of how to set a financial value on a physician's practice, examine what capitation is and suggest ways of dealing with it, provide management solutions to create profitable opportunities in the government/business politics of health care reform.

A panel of esteemed Colorado physicians and health care professionals, including CMS members Leigh Truitt, MD, Melvyn H. Klein, MD, and Judith K. Bodnar, MD, will field questions from the audience. This conference is designed to help physicians control their own destiny. All physicians combating the dominant role of "managed" health care delivery in Colorado are encouraged to attend. For more information please call Managed Care Initiatives at (303) 674-8581.

Corrections

The cover of the July, 1996, *Colorado Medicine* (Issue #7) contained erroneous information due to the transposing of two figures. The late Frederick A. Lewis, Jr., MD, was born on February 28, 1927, not February 27, 1928, as the picture caption stated.

The Colorado Medical Society Alliance (CMSA) General Meeting during the 1996 CMS Annual Meeting in Steamboat Springs will be held at 9:30 AM to 12:00 PM on Friday September 20. The information provided on page 246 of this month's edition of *Colorado Medicine* is incorrect. The General Meeting will last until noon instead of the reported 11:00 AM.

Another newborn screening law passed

As of July 1, 1996 all infants born in Colorado who receive newborn screening according to the current newborn screening laws will be required to have a second specimen taken. This additional test will screen for the following conditions: phenylketonuria, hypothyroidism, galactosemia and cystic fibrosis. The new law also mandates that a second screening shall be taken for accurate test results and other conditions may be tested which the State Board of Health deem necessary for timely and effective diagnosis and treatment of newborn infants. For more information about the statute, please contact Jim McKinna at the Colorado Department of Public Health and Environment.

Colorado physician pioneer dies

Clayton L. Hawkins, MD died June 30, 1996. Dr. Hawkins was 100 years old. Funeral services were held at Zion Baptist Church in Denver on July 6, 1996.

CMS Historian John L. Lightburn, MD recently profiled Dr. Hawkins in the March 1996 edition of *Colorado Medicine*. Highlighting the joys and tribulations of Dr. Hawkins' 53 years of general practice in Denver, the biographical sketch portrays the enduring spirit of medicine that continues in Colorado today. Dr. Hawkins said that the profession of medicine was "stimulating." Indeed, the health of many Coloradans was touched by the care and integrity with which Clayton L. Hawkins practiced his art.



CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Colorado Commission on Family Medicine
1996 Opportunities Fair and Annual Conference
September 6-8, 1996
Copper Mountain Resort, Colorado
(303) 745-4275

Colorado Hospital Association
Annual Meeting
September 11-13, 1996
Vail, Colorado
(303) 758-1630

American College of Cardiology
Enhancing Quality and Value in Cardiovascular Care
September 18-21, 1996
Vail, Colorado
22 Category 1 AMA
1-800-253-4636 ext. 695

Rky. Mtn. Cardiovascular & Health Promotion Conf.
CU School of Medicine and Office of CME
September 19-20, 1996
Vail, Colorado
(303) 372-9050 or 1-800-882-9153

HIV Clinical Training Program
Col. AIDS Educ. & Training Cntr. and UCHSC
September 18-20, 1996
Denver, Colorado
(303) 355-1305

University of Colorado's CME in the Rockies
Rky. Mtn. Correctional Health Care Conference
October 1996
Denver, Colorado
(303) 372-9050 or 1-800-882-9153

Colorado Hospital Association
17th Annual Statewide Trustee Conference
October 3-5, 1996
Lakewood, Colorado
(303) 758-1630

Colorado Physicians

Managing Managed Care 1996
October 5, 1996
Denver, Colorado
(303) 674-8581

Colorado Hospital Association
Restraints and Seclusion: Addressing the Issues/
Complying with Standards
October 7, 1996
Lakewood, Colorado
(303) 758-1630

Colorado Hospital Association
Performance Improvement Standards in Home Care
Organizations
October 10-11, 1996
Denver, Colorado
(303) 758-1630

University of Colorado's CME in the Rockies
42nd Family Practice Review
October 28-November 1, 1996
UCHSC, Denver, Colorado
(303) 372-9050 or 1-800-882-9153

The Prosper Meniere Society
MGMA/CRAHCA
Physician Services Practice Analysis Software Hands-on
Training and Report Analysis Workshop
November 7-8, 1996
Englewood, Colorado
(303) 397-7876

HIV Clinical Training Program
Col. AIDS Educ. & Training Cntr and UCHSC
November 13-15, 1996
Denver, Colorado
(303) 355-1305
8th Annual Seminar and Workshops: Diagnostic and
Rehabilitative Aspects of Dizziness and Balance
Disorders
December 4-7, 1996
Denver, Colorado
Contact: Jane Wells, (303) 788-4235



EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



We think with the passing of every year that we've seen the extremes in health care and that we will be getting back on an even keel.

We continue to think this, despite the latest developments that seem to continually erode the role of the physician in the overall scheme of things. We think, too, that there may not be a place or a need for organized medicine in the new managed care/health care blueprint. Most everyone is ready to resign themselves to the idea that every doctor will soon be an employee of a single health superpower.

Then there's a spark, typical of some legislation that turns the tide in favor of the physician. For example, the so-called "Anti-Gag" legislation that was passed this session because of the efforts of Dr. Joel Karlin and the Colorado Medical Society, or the legislation that says physicians can form networks to contract with health maintenance organizations or act independently as an HMO.

These seem, on the face of it, to be small items but they are important stepping stones that help doctors maintain their footing in a rocky health care environment.

So what's CMS, the organization, doing about warding off a complete takeover of medical practice by non-physician influences? We're doing our job: analyzing the threat and developing responses.

- CMS staff, in support of councils, committees and task forces, is busy looking at the physician needs and investigating ways to meet these needs. We're busy now

analyzing the expressions of the 1996 Leadership Conference in May. We will soon have a conference summary so that leadership can act on the recommendations and requests made. Example: staff is presently exploring the development of a CMS web page on the Internet. "Web page?" you say; "What the Hell for?" That's what we're exploring now, and we'll complete a thorough investigation of this recommendation (made by several physicians at the Leadership Conference) so that members are in a position to make the best move.

- CMS is presently preparing for the 126th Annual Meeting of the House of Delegates, to consider propositions for the coming year. CMS leadership is already meeting to consider legislative positions in Colorado for the 1997 General Assembly session. January is not far away. During the past year CMS has spent approximately 25% of its energies on legislation, and our score card shows that we have been effective.
- CMS members and staff are examining possibilities for improving member communications, including computer network, print, electronic, video conferencing and other methods of interactive communication.
- CMS has a speedy response system in place, whereby we can reply immediately through the news media to public questions or statements.
- CMS is currently in the midst of a campaign to strengthen the linkage between physician and patient

through our **"Physician Profile Project"**. We've taken an aggressive first-step on the path that's carrying us toward "outcomes studies" and published results. In this program, we've provided our members with the first elements of a new doctor-patient relations program. All they have to do is pass the elements along to their patients.

- CMS is still the magnetic pole for over 5,000 Colorado physicians. It was founded 125 years ago "to promote the art and science of medicine and to improve the public health."

I think this says it best: "While there is no question that much has changed since 1871, the CMS' goal is still much the same. Its key objective is to foster an environment that supports member physicians' efforts to provide patients with high quality, affordable health care by: 1) advocating on behalf of patients and physicians in health policy forums; 2) promoting self-regulation of the medical profession; 3) advancing medical science, education, and accreditation; and 4) disseminating information on the art and science of medicine to the public and to the medical community."*

* Reprinted from *"Your Guide to Medical Democracy in Action: Colorado Medical Society's House of Delegates, Resolutions and Reference Committees"*
1995 Fifth Edition
Ted T. Lewis, MD, Speaker of the House
Louise L. McDonald, MD, Vice Speaker



When you make the decision...

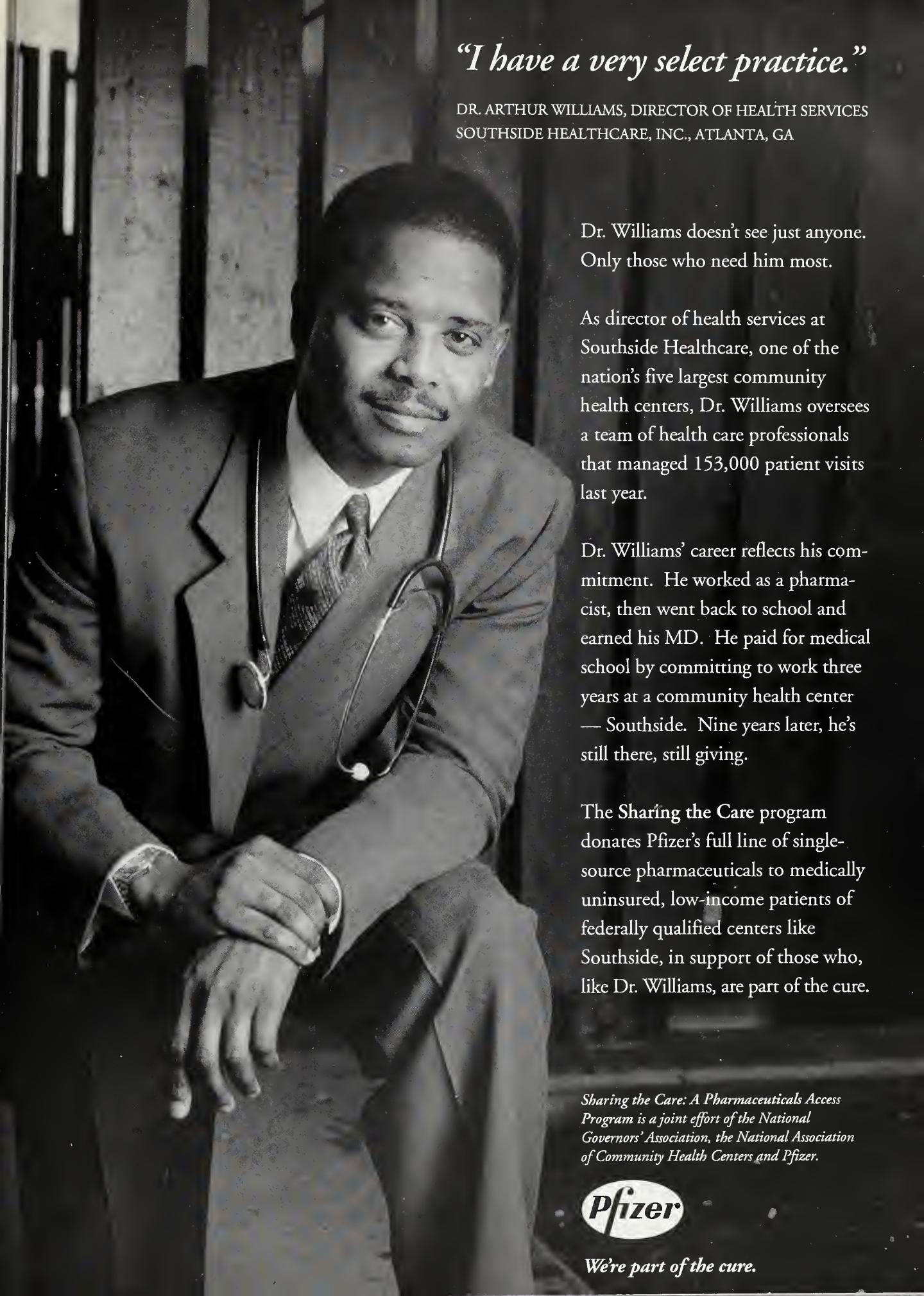
American Medical Association
Physicians dedicated to the health of America

Closing Your Practice

Department of Practice Development Resources

... here's the book you need, to do it right!

The AMA Department of Practice Development Resources has made available this booklet giving you the fiscal, legal and ethical answers to all those questions when you decide to close your practice. You can order the book by calling 1-800/621-8335. The order number is OP381689RY. Price of the book is \$19.95 for AMA members, \$24.95 if you are not a member.



"I have a very select practice."

DR. ARTHUR WILLIAMS, DIRECTOR OF HEALTH SERVICES
SOUTHSIDE HEALTHCARE, INC., ATLANTA, GA

Dr. Williams doesn't see just anyone.
Only those who need him most.

As director of health services at Southside Healthcare, one of the nation's five largest community health centers, Dr. Williams oversees a team of health care professionals that managed 153,000 patient visits last year.

Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



We're part of the cure.

T elemedicine in Colorado

Rural health gets connected

"The majority of rural practitioners ... are very satisfied with the system and participating consultants."

On August 11, 1995 Melissa Memorial Hospital (Holyoke) and Provenant St. Anthony Hospital Central made history. It was on that day that the two hospitals made the first interactive telemedicine consult on the **High Plains Rural Health Network** (HPRHN). Since then, there have been numerous consults, administrative conferences and educational programs (see *figures next page*) over the system. Funded by two federal grants, there are ten sites that have the ability to connect with each other. Another four sites will be added by the end of this summer, and a third grant will boost the total to over twenty sites.

The HPRHN telemedicine project is somewhat unique in its structure and objectives. First, by building a network that includes sites in three states (Kansas, Nebraska and Colorado), the staff is able to study cross-state issues, such as physician licensure and network infrastructure. Second, the HPRHN project is one of the few in the United States that is not based out of a single tertiary facility or university. Rather, the project currently includes specialists from two urban tertiary hospitals and one rural regional medical center, with more to be added with a third grant. In many instances, rural hospitals and providers have established referral relationships with a variety of urban providers, giving the rural facilities choices in their contacts. The HPRHN network hopes to reinforce those choices.

According to data gathered from the first six months of operation, patients and telemedicine practitio-

ners like the technology. The patients enjoy the convenience and most consider the teleconsult as good as, or even better than a face to face visit (since they do not have to travel). Every patient who participated in a teleconsult indicated that they would do so again. The majority of rural practitioners, many of whom initiate the teleconsults for the purpose of management and treatment, are very satisfied with the system and participating consultants. The consulting physicians also indicated that they are very pleased with this method of patient care. In most cases they are able to reach a working diagnosis using the technology, and only a handful of patients need to be seen in person following the teleconsult.

As efficient as the technology is, there are some barriers to its use. First, there is the cost of building a network. While many of the costs associated with purchasing the actual telemedicine equipment have decreased, Colorado has some of the highest transmission fees in the nation. Most rural hospitals simply cannot afford these rates. The recently passed federal telecommunications bill may lower costs, however a great deal of input from rural consumers and health care providers is needed to develop an affordable pricing structure. Instead of depending on this new legislation, HPRHN is cutting transmission costs by implementing technologically advanced systems that bundle many different forms of information (voice, data, video) over one line.

(Continued next page)

Reimbursement is the second barrier because payment policies for telemedicine services are not widely approved. Seven states have negotiated agreements with Medicaid to reimburse those services, but at this time Colorado has not established a reimbursement policy. HPRHN has sent its reimbursement proposal to over 70 insurers and has begun meeting with some of the larger third-party payors, including Colorado Medicaid, in an effort to obtain reimbursement for the valuable services practitioners are providing.

The last hurdle deals with cross-state licensure. Until a national telemedicine license or some other practice mechanism is developed,

HPRHN is encouraging participating specialists to become licensed in the states where they will be providing services.

HPRHN welcomes input from the Colorado Medical Society and its members regarding these and other related issues. The benefits of telemedicine are many, however, the health care organizations of Colorado must find common ground in order to make this technology affordable and efficient.

For more information on the High Plains Rural Health Network please call Lee Green at (970) 867-6195, or visit their web site on the World Wide Web at <http://www.yampa.com/HPRHN>.

You didn't spend umpteen years in school in order to become a bill collector.

Collecting money from slow paying patients is critical to your practice. But you didn't spend all those years in school to become a bill collector.

And that's where I.C. System can help.

First of all, we have the resources and expertise to do the job. And while we're tenacious, we treat your delinquent patients with courtesy and respect.

In fact, our work is endorsed by over 1,200 professional associations and societies, including the Colorado Medical Society. And no matter where you're located or where your debtors live, we have local representatives to service your account.

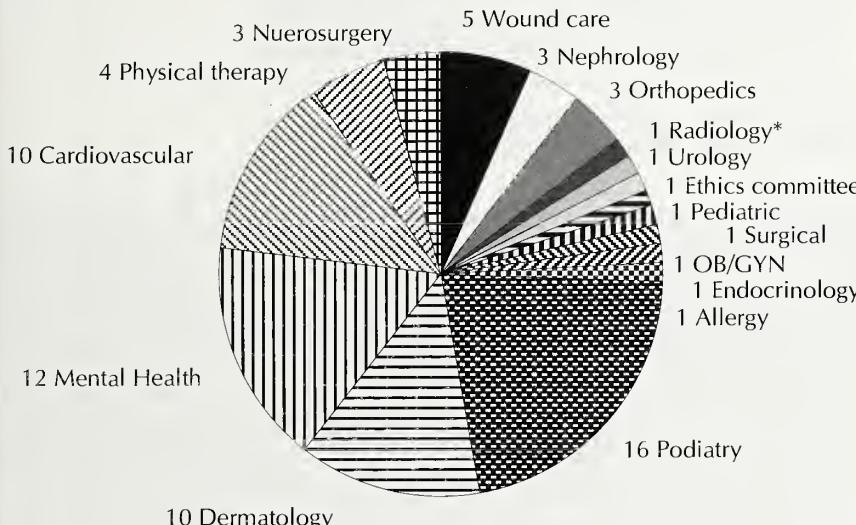
But most important, we guarantee results, by collecting at least ten times the amount of our retainer.

To find how the I.C. System approach can work for you, call toll free (800) 824-9469, ext. 330.

I.C. System
The System Works®

Types of HPRHN Telemedicine Consults

August 15, 1995-June 30, 1996



* The system uses interactive video. No tele-imaging is used for radiology.

Usage of HPRHN Telemedicine System

July 27, 1995-June 30, 1996





COLORADO MEDICAL SOCIETY ALLIANCE



by **Stella Shanks, President**
Colorado Medical Society Alliance

The Annual Colorado Medical Society Alliance (CMSA) meeting is an opportunity to review and address our efforts. It also provides a time to enjoy a beautiful fall weekend in the mountains. This year's Annual Meeting in Steamboat Springs will undoubtedly be another great one.

Please join the Alliance Saturday September 21 to hear how Colorado Physicians Health Program (CPHP) has helped participating families. Dr. Stephen Dilts and Dottie Moffett will direct this presentation and explain how to access CPHP services. Three spouses will give first hand accounts

of their experiences. Afterwards, Dr. Richert Quinn of Copic Insurance will discuss how to deal with family stress during a medical malpractice suit.

Other important reasons for you to attend the CMSA meeting in Steamboat Springs include: a follow up session to "Unplug the Holiday Machine", a gondola ride and hike to Thunderhead peak for lunch and a decorating workshop by Suzy Lord of Barton's Interiors.

Please take a moment to fill out the registration form below and return it to me as soon as possible. I look forward to seeing you at the

Annual Meeting.

On a side note, I am happy to report that the Colorado Medical Society Alliance has received the **Five Percent Plus Award**. Thanks to a lot of hard work, in particular by three counties, Alliance membership has increased. Pueblo county had an impressive 97 percent increase, Metro Denver had a strong showing with a 15 percent surge and Larimer county cinched the award for CMSA with a five percent jump. Congratulations! We are very proud of you.

Colorado Medical Society Alliance 1996 Annual Meeting Registration

Sheraton Resort and Conference Center, Steamboat Springs, Colorado
September 19-22, 1996

Name: _____

County Alliance: _____

Friday, September 20, 1996

8:00 - 9:15 am

Board Meeting

Will Attend _____

9:30 - 11:00 am

General Meeting

12:15 - 1:45 pm

CMSA COMPAC Lunch (\$20)

2:00 - 3:30 pm

Decorating Workshop

3:30 - 5:00 pm

Visit Barton's Shop

Saturday, September 21, 1996

8:00 - 9:00 am

All Members Breakfast

9:00 - 10:30 am

CPHP Presentation

10:45 - 11:30 am

Copic Presentation

Noon -

Gondola Ride (\$12)

Box Lunch (\$11)

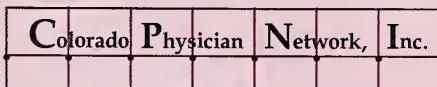
TOTAL

\$ _____

Make checks payable to **CMSA** for total food charges and gondola ride.
Mail to: Stella Shanks, 2606 Kelley Dr., Grand Junction, CO 81506.



A collaboration of



ROCKY MOUNTAIN HMO

Now offers

A special enrollment opportunity

to participating physicians
and their office staff
as employer groups.

Initial implementation and marketing of this bold new venture are underway in:

- Southern Front Range
- Eastern Plains
- Northwestern Colorado

Take advantage of this unique collaboration in health care by becoming a **member** as well as a **provider**!

Call 1-800-453-2981 to learn more.

CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



If Copic Can Pay Distributions, Why Can't It Reduce Premiums?

On more than one occasion, Copic has received calls and letters asking the question posed in the title. Although it seems as though the answer ought to be simple, the reality is a bit more complex and is grounded firmly in Copic's mission.

Our mission statement directs us to accomplish the goal of providing insurance products through "sound management, financial strength (emphasis added), optimum service, risk management, educational activities, strong leadership, and advocacy." In order to be strong financially, every single year an insurer must have:

1. Premium volume sufficient to cover the year's actuarially-projected losses
2. Reserves sufficient to cover losses as they develop from previous years

Copic has always taken a fiscally conservative approach when setting annual premiums. We use three different actuaries (one in-house and two consulting actuaries). Each actuary uses a different approach to arrive at a range of recommended premiums. The high end of the range is designed to show the effects of the "worst-case scenario."

Our commitment to financial stability leads us naturally to adopt at least the low end of the range so that we can be certain we'll always

be able to cover our losses.

Copic has pledged to operate its professional liability insurance activities on a not-for-profit basis. On occasion our loss experience falls short of actuarial projections, leaving a surplus available for distribution back to policyholders. There is a catch, however. Full claim development takes a long time. There's often a four to five year lag between the time the original premium payment is made and the time at which we can determine the existence and magnitude of any surplus attributable to that payment. When you understand that current-year premium volume must be sufficient to cover current-year actuarial loss projections, you'll see that it would be unsound fiscal practice to use any distribution as a "discount" off of those current-year premiums. There are other concerns as well about positioning distributions as discounts. First, when the premium is "camouflaged" in this manner, it has the potential to mislead not only insured physicians, but also a company's reinsurers and other regulators. Second, since distributions are never predictable or guaranteed, you'd have to play catchup by "raising" premiums the first year you fail to have a distribution. It is for these reasons that Copic's policy is to account for distributions as a credit against your balance rather than as a reduction in that year's properly-set premium.

These reasons also drive Copic's treatment of loss reserves. The amount of these reserves is determined each year by Copic's accountants using procedures standard to the industry. Once reserve levels are determined, many insurers "discount" them -- in other words, they subtract an amount equal to the amount they anticipate earning from investment income. It's easy to see how this practice could lead to the same problems that occur in our example of using distributions to discount premiums. If an insurer discounts loss reserves and investment income subsequently falls short of expectations, the reserves would be inadequate and the insurer's financial stability would be threatened. Our duty to protect Copic's financial stability guides us to refrain from this practice.

Since its inception, Copic has taken in \$69.9 million in investment income and paid out \$45.6 million in direct operating expenses. That means that Copic has never used a single dollar of your premium payments to pay for running the company. To answer the question posed in the title, we can only respond that doing so would run counter to our mission statement and would threaten the financial stability our policyholders demand and deserve.

Remember:

Your membership in COMPAC will assist with financing the campaign of legislators who are supportive of medical practice issues. 1996 is already a critical legislative year to medicine, so help however you can.



Colorado Medical Society
Women in Medicine Section
(WIM)
Presents

**Women Physicians in
Today's Medical Culture –
Do They Flourish or Perish?**



Clydette Stulp, Ed.D.,
Department of Family Medicine
University of Colorado
Health Sciences Center.

Clydette Stulp, Ed.D., will speak at the Women in Medicine Section's business and dinner meeting Friday, September 20, during the CMS Annual Meeting. Her presentation will highlight two years of work spent interviewing women physicians and focus groups. The survey results represent women in medicine from 23 different specialties and examines factors contributing to job satisfaction, major challenges to practicing medicine in the 1990's and ways women have chosen to maintain integrity in their work.

In addition to focusing on survey data, an interactive question and answer session will engage audience members to examine how they can continue to make medicine a healing art as the next century approaches.

Ms. Stulp is an Assistant Professor and Director of Behavioral Sciences in the Department of Family Medicine at the University of Colorado Health Sciences Center. She has worked in family medicine for the past 15 years.

Please call Cindy Wooley at (303) 779-5455, ext. 419 to register for this provocative event.

Watch for other Women in Medicine Section information in the next WIM Newsletter.

Assistant Administrator Medical Affairs

North Colorado Medical Center in Greeley has a full-time opportunity available. NCMC is a 326-bed facility located in Northern Colorado. We are a member of Western Plains Health Network, a seven hospital network, with related non-hospital services. In this position, you will serve as a resource to this network and will be involved in multi-facility functions. You will also serve as the primary administrative liaison to the medical staff, oversee medical staff office, have administrative responsibility for quality of care programs (credentialing, risk management, quality improvement, infection control and safety issues), and serve as a medical resource to hospital management and staff.

As an excellent communicator, you will be a member of the hospital's senior management team. Requires an individual who is an MD/DO eligible for licensure in Colorado with a minimum of 5 years clinical practice. We prefer applicants with previous management experience in the medical, clinical or hospital environment and involvement in quality improvement. Knowledge and experience in managed care settings is highly desirable.

We promote a drug-free environment and drug screening is required. Please send or fax your resume to: North Colorado Medical Center, Attn: K. Gills, Administrator, 1801 16th Street, Greeley, CO 80631. Equal opportunity employer.



North Colorado Medical Center
A member of Western Plains Health Network

**"You can't tell the players
without a scorecard."**

and **THE** scorecard is
the twice-monthly newsletter

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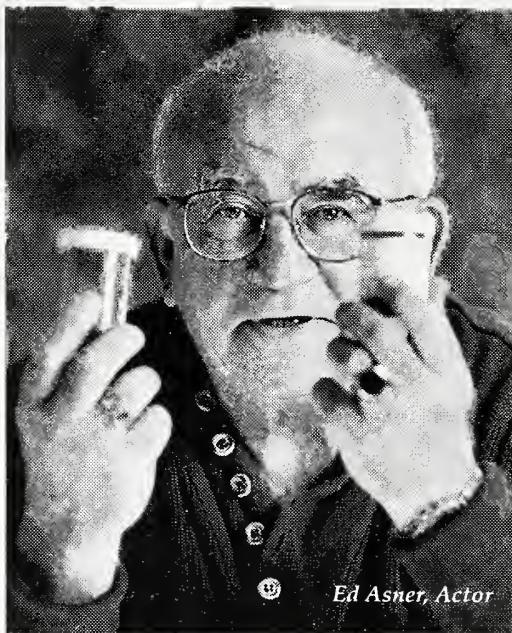
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HCCA, 655 Broadway, Denver, CO 80203.

Attention: Physicians



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

Write for *free information* on patient medicine counseling.

Mail to:



NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

OR FAX:
(202)638-0773



by **John Lightburn, MD**
Historian
Colorado Medical Society

Birth of the Colorado Medical Society

Because the Annual Meeting in Steamboat Springs will commemorate the 125th year of the Society, we will postpone the second article on the contribution of religious and charitable organizations to medical care in early Colorado until next month. This month we print an abridged version of a chapter by Judith Hannemann in A CENTURY OF COLORADO MEDICINE, 1871-1971 edited by Harvey Sethman and published by the Colorado Medical Society.

Judith Hannemann was the wife of a radiologist and a gifted writer and historian.

As soon as the structure of the Denver Medical Association was down on paper and there were officers to conduct the duly recorded proceedings in the spring of 1871, it was time for Denver physicians to look at the profession's needs beyond their own city. In the thirteen years following the first gold discovery along the sandy banks of the South Platte River, Colorado had grown from a wilderness to a Territory with a population of 39,842.¹ More people meant more doctors. With statehood on the horizon, the physicians of Colorado needed the fraternity, certified credentials and continuing scientific education provided by a professional society.

Five members of the Denver Medical Association agreed to take charge of arrangements for a convention of all physicians practicing

in the Territory. W. H. Williams, W. F. McClelland, H. K. Steele, A. Stedman and H. O. Dodge planned the convention's proceedings from the opening prayer of invocation to the final dinner celebration at Ford's Restaurant.²

W. H. Williams, a consumptive, took personal interest in organizing a Territorial medical association. He had served four years in the Confederate Army, graduated from the University of Louisiana in 1867 and settled in his home town of Lexington, Mississippi, to practice medicine. Two years later he was west bound in search of the cure. His lung hemorrhages ceased while he was passing through a small town named Denver on the eastern side of the Rocky Mountains and he decided to stay there. His life, if not his health, was indebted to the Colorado climate and he never intended to forget the debt.³

After graduation from the Jefferson Medical College in 1849, William F. McClelland had practiced in Council Bluffs, Iowa, for several years. There was just something about taking a chance and going West that appealed to him. In June of 1862 he arrived in Denver to accept a new job as surgeon of the Denver Military Hospital. Within two years, his fortunes flourished with an appointment as permanent medical examiner of Equitable Life Assurance of New York for Colorado, Wyoming, and New Mexico.⁴

Forty-six-year-old Henry K. Steele was the most recent member of the Denver Medical Association to reach Denver. Upon receiving his M.D. from the University of New

York in 1848, he went back home to Dayton, Ohio, where he practiced medicine for twenty-three years. Service in the Forty-fourth Ohio Volunteer Infantry expanded his world enough that he was not willing to settle into his old ways after the War ended. In February of 1871 he came to Denver and began practicing.⁵ Because he had been a member of the American Medical Association for twenty years, his ideas on organizing a medical society were invaluable to the planning committee.

Arnold Stedman's education at Colby University had been interrupted by the Civil War. After service as Orderly Sergeant of Company K, Twenty-second Regiment of the Maine Infantry, he graduated from the Berkshire Medical College in 1865 and opened an office in Dexter, Maine.⁶ He was thirty-one years old with nothing to lose and a wanderlust to satisfy when he first saw Denver from the top of a six-horse Concord coach on an April Sunday morning in 1870.⁷

Horace O. Dodge had been matriculated in Wheaton College one month when he volunteered for service in Company E of the Eighth Illinois Cavalry. He finally graduated from the Chicago Medical College in 1868 and worked for three years in the Chicago Hospital for Women and Children until a yen to see the West brought him to Colorado in January of 1871.⁸

By the end of July, these five physicians had mailed two hundred invitations to doctors in the Territory. The invitations summoning physicians to attend a convention in

Denver on September 19, 1871, went as far west as the high country towns of Central City, Idaho Springs, Black Hawk and Georgetown, as close as Golden nestled in the foothills west of Denver and south to

H. Kehler, founder and rector of St. John's Church in the Wilderness, had seen his share of "firsts." After his retirement from the ministry in West Virginia at the age of sixty-five, Father Kehler traveled to Colorado in



The charter meeting of the CMS was accommodated in the District Court room above a store at the corner 15th and Lawrence Streets. (Denver Public Library Western Collection)

Pueblo beside the wide banks of the Arkansas River.⁹

Sixteen physicians and a guest clergyman climbed an outside staircase to the District Court Room above a general store on the corner of Fifteenth and Lawrence Streets for the charter meeting of the medical society on the appointed day. W. F. McClelland called the convention to order with his nomination of G. S. McMurtrie of Central City as the Temporary Chairman. The first nomination having passed unanimously, R. J. Collins of Georgetown was chosen secretary pro tem.

Russell Jarvis Collins was a graduate of the Berkshire Medical College. He headed West in 1866 with the intention of starting a practice at Empire, Colorado. Eight physicians ministered to the populace of 1,596 in Clear Creek County by 1870. Dr. Collins moved on to Georgetown to enhance his practice in competition with four other physicians and found his work doubled in the new location.¹⁰

A prayer of invocation was scheduled for the opening of the convention. The Reverend John

1860. He conducted the first Episcopalian church service in the Rocky Mountains and it turned out to be far from his last.¹¹ He had been pastor of Denver's Episcopalians for eleven years as he offered a prayer of invocation for the assembled physicians.

A. L. Justice presented the first resolution which read: "That for purposes of organization, all regular graduates of Medicine, residents of this Territory, who acknowledge fealty to the Code of the Ethics of the American Medical Association, and who are not objected to, may become members of this Association by signing their names to this resolution at the Secretary's table."

Denver physicians signing the resolution were Richard G. Buckingham, Frederick J. Bancroft, H. O. Dodge, A. L. Justice, W. F. McClelland, E. C. Gehrung, John Elsner, J. S. Dickinson, H. K. Steele, Arnold Stedman and W. H. Williams. I. J. Pollock and R. J. Collins of Georgetown placed their names beside those of G. S. McMurtrie, W. Edmundson and S. D. Bowker of Central City.¹²

The sixteen signers of the chartering resolution had put aside the treatment of pneumonia, scarletina, tuberculosis, cholera, smallpox, measles, dysentery, peritonitis, diarrhea, bronchitis, typhoid, and mountain fever to tend to the organization of a professional society. In their bags they carried a pharmacopoeia of calomel, quinine, gentian or jalap, veratrum viride, morphine and whiskey.

Frederick J. Bancroft hoisted his three hundred pounds out of a chair to make a motion that all physicians visiting the Territory be invited to participate in the proceedings of the new organization. Frederick Jones Bancroft had been graduated from the Medical Department of the University of Buffalo in 1861. His course of postgraduate study at the University of Pennsylvania was interrupted when he joined the Seventy-sixth Pennsylvania Volunteers. He had taken command of Church Hospital in Harrisburg, seen service in the New York yellow fever epidemic and set up a hospital for Confederate prisoners before relinquishing his blue uniform to become a surgeon for Wells, Fargo and Company Stage Lines at its Denver station in 1866. The Kansas Pacific and Denver Pacific railroads had lured his medical talents away from Wells Fargo a year before the medical convention.¹⁴

John Elsner came to Denver to practice medicine in the same year as F. J. Bancroft. A native of Vienna, Elsner's graduation from the New York Eye and Ear Infirmary in 1863 earned him an appointment as U.S. Examining Surgeon aboard the U.S. Receiving Ship *Ohio*. After being mustered out of the military service, he took additional courses at Bellevue Hospital Medical College and received his doctorate in medicine in 1866.

In 1870 he had succeeded in convincing the Denver city fathers that the city was in dire need of a County Hospital. Dr. Elsner took charge of the construction of the wooden edifice on the west side of Cherry Creek below Blake Street.¹⁵ He had the questionable honor of

being the City Physician and was obviously well acquainted with the ins and outs of conducting politic business with his motion that the



*Richard G. Buckingham, MD
First President of
Colorado Medical Society*

press be invited to attend the medical convention.

Housekeeping necessities of the convention being in order, the president of the Denver Medical Association, Richard Green Buckingham, was introduced for the Opening Address. Dr. Buckingham had earned his medical degree from the Berkshire Medical College in 1836. He practiced in the frontier town of Lexington, Missouri, for twenty-one years until the lure of another frontier farther West nudged him into crossing the plains to Denver in 1863.¹⁶ Buckingham and his young friend Arnold Stedman had dreamed up the Denver Medical Association during the winter of 1870-71. Buckingham was fifty-five years old with thirty-five years of practicing medicine to his credit as he addressed the assembled physicians.

A desire to honor the profession had called them together today, he said in his opening remarks. Their professional calling was a dignified one which seldom received the honor due its services to mankind and the community. The physician's days of happiness and nights of bliss, after all, were those of toil and sympathy for the distressed and dying. The recompense for these

labors was all too frequently an inward joy at doing good.

A properly conducted Territorial medical organization would advance the profession's best interests in the community, provide social communion and establish enduring friendships among the members, he said. Of greater importance was the mutual study of medicine which would sharpen the ability to diagnose disease and apply appropriate remedies. Auxiliary to the Territorial association, county medical organizations should be established and meet frequently.

Buckingham suggested that the physicians gathered in the District Court Room turn their attention to organizing a Territorial Medical Association of Colorado in hopes that it might someday rest upon as firm a basis as the grand old mountains before them that lift snowcapped summits to the clouds.

With Dr. H. K. Steele as chairman, a committee of Doctors Pollock, Bowker, Edmundson and a late arrival from La Porte named T. M. Smith was appointed to draft a Constitution and By-Laws during a luncheon interlude scheduled until two o'clock.

The jagged peaks west of Denver were limned with the yellow orange of a setting sun as the physicians finished their deliberations and votes on each of the seven articles of the Constitution and its six By-Laws. The election of officers remained on the agenda before the

convention could recess. Two latecomers brought the number of voting physicians to eighteen. In the election for presidency, Richard G. Buckingham received thirteen votes with three cast for G. S. McMurtrie and two for F. J. Bancroft.¹⁹ I. J. Pollock would serve as Vice-President, Arnold Stedman as Secretary, E. C. Gehrung as Treasurer and H. O. Dodge as Librarian for the nascent Society.

Dr. McMurtrie gallantly relinquished his temporary possession of the Chair by escorting the newly-elected president forward to conclude the afternoon's business. Irving Pollock moved that a committee be appointed to draft a fee scale and was promptly appointed to chairmanship of the committee.

Selecting delegates to attend the next meeting of the American Medical Association was the next order of business. Doctors McClelland, Williams and Holland were elected.

Fifty-year-old Eugene F. Holland had not arrived until late that afternoon and had missed signing the chartering resolution. He had been prospecting and practicing in Colorado since his arrival in Clear Creek in 1860. Eight years of discouraging adversity that did not yield enough color to pay his living expenses prompted him to forsake mining and establish himself in Idaho Springs as a full time practitioner of medicine.²⁰

(Continued on following page)



The banquet of oysters and duck was served at Ford's Restaurant three doors down on Larimer Street (Courtesy of Denver Public Library Western Collection)

ARCHIVES (Continued)

As the last order of business facing a restless convention, H. K. Steele read the Code of Ethics of the American Medical Association. It was unethical to advertise by puffs in newspapers or medical journals, to procure reputation by cliques or mutual agreement with individuals in the profession or to specialize in diseases other than those of the lungs, uterus, or digestive organs.²¹ Dr. Steele's address concluded the first meeting of the Colorado Medical Society.

In addition to the sixteen signers of the original resolution, nine other physicians managed to be considered original members of the Society. They included William H. Thacker, D. Heimberger and Charles S. Neilson of Denver, T. M. Smith from La Porte, Eugene F. Holland from

Idaho Springs, Joseph Anderson from Golden, T. R. Thombs from Pueblo, S. C. Tolles from Central City and Erasmus Garrot from Black Hawk.

Barney Ford, Denver's touted restaurateur, had prepared one of his famous oyster and duck suppers for the convention delegates. Nine physicians having straggled in during the course of the meeting, the number of guests at Ford's Restaurant on Larimer Street was twenty-five. Generous pourings of red and white wines from Ford's cellar facilitated toasts to the American Medical Association by Dr. McClelland, appropriately followed by Dr. Buckingham's toast to the Colorado Medical Society. Dr. Bowker added levity with his toast to the absent ladies. Toasts were drunk to legitimate medicine and the press in concluding the night's revelry.²²

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Colorado	Physician	Network	Inc.
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by David C. Martz, M.D., President
Colorado Physicians' Network

"The Shoe Fits!"

"The Cobbler's Children have no shoes!" How often this timeworn adage is evident in the world around us. Each of us could offer dozens of examples.

Rocky Mountain Physicians' Choice will not be one of those examples!

As marketing of products gets under way, Rocky Mountain HMO has agreed to offer participating physicians and their office employees early enrollment. This is an ideal opportunity for us to take advantage of our unique cooperative venture and secure the finest in health care for our employees and families.

And what a statement it will make to our patients in the days ahead. Personal participation is always far more persuasive than mere endorsement. Likewise, although we cannot formally market the products ourselves, experience on the Western Slope has shown that the physicians' confidence in the plan has been very powerful.

So take advantage of this special opportunity. Call the Rocky Mountain HMO regional office in Pueblo at (719) 543-7636, or call 1-800-453-2981 to learn how you can experience Rocky Mountain Physicians' Choice both as provider and consumer. If we take the lead as participants, we can both know and model how beautifully "the shoe fits!"

NOTE: Phase I marketing of the **Rocky Mountain Physicians' Choice** product includes the southern Front Range: Colorado Springs, Pueblo, San Luis and Arkansas Valleys and the Eastern Plains. Northwestern Colorado in the Craig area will also be included.

Medical Practice in the Year 2000 and BEYOND

SPECIAL SECTION
on the
Colorado Medical Society
126th Annual Meeting
of the
House of Delegates
September 19-22, 1996
Sheraton Steamboat Springs
Resort & Conference Center

As physicians of the Colorado Medical Society prepare to celebrate 125 years of organized medicine, they also are planning for the future and a new century. They are looking to the year 2000 and beyond in the continuing evolution of health care.

On behalf of the Colorado Medical Society House of Delegates, we urge you to participate in this planning process by attending the Annual Meeting of the Colorado Medical Society, to be held September 19-22, 1996, Sheraton Steamboat Springs Resort and Conference Center.

General Membership of CMS is urged to attend!

Annual Meeting Registration

1996 Annual Meeting of the Colorado Medical Society and CMS Alliance
 September 19-22, 1996, Sheraton Resort, Steamboat Springs, Colorado

Name (please print) _____

Component Society _____ Name of Spouse/Guest(s) (if attending) _____

If you are not a member of CMS, please provide the following:

Company/Organization _____ Title _____

Reservations for Events and Meetings

Reservation deadline is August 29, 1995. (Note: To attend the President's Dinner Dance on Saturday, you **must confirm** your tickets before noon, Friday, Sept. 20.) Reservations accepted on a first-come, first-served basis (may be limited for some programs). For purposes of registration, staff of county medical societies are considered members. You must indicate the number of attendees for each function so that we may be cost efficient with food/beverage orders.

As a member, **you and one guest are entitled to attend the complimentary events at no charge**. Please indicate the number of additional guests at the bottom of this form and enclose your check.

Complimentary events open to all members: Please indicate below which functions you will attend.

THURSDAY, SEPTEMBER 19

6:00 pm Welcome Reception member

guest

FRIDAY, SEPTEMBER 20

7:00 am New Delegate Orientation Breakfast member

guest

7:00 am AMA Delegation Forum Breakfast member

guest

4:30 pm CMS Alliance Reception member

guest

(for Alliance members & interested spouses)

5:30 pm Exhibitor Reception member

guest

SATURDAY, SEPTEMBER 21

7:00 am Educational Program Continental Breakfast member

guest

8:00 am Educational Program member

guest

12:15 pm COMPAC Political Campaign Seminar member

guest

7:00 pm President's Dinner Dance:

(Please select menu from below)

Beef and Chicken Dinner member

guest

Vegetarian Dinner member

guest

Vegan Dinner member

guest

9:30 pm Copic Dessert Reception member

guest

Additional Reservations (other than member + 1 guest):

Educational Program Breakfast # _____ @ \$15 each= _____

President's Dinner Dance (**Reservations necessary**, please select menu below)

Beef and Chicken Dinner # _____ @ \$50 each= _____

Vegetarian Dinner # _____ @ \$50 each= _____

Vegan Dinner # _____ @ \$50 each= _____

..... Total for Additional Reservations \$ _____

Non-Complimentary Events:

Cost **Number**

FRIDAY, SEPTEMBER 19

12:15 pm COMPAC/CMSA Luncheon \$20 each

..... Total for Non-Complimentary Reservations \$ _____

Total enclosed for non-complimentary and/or additional reservations \$ _____

After completing this form, please mail it to us (at PO Box 17550, Denver, CO 80217-0550), phone it to us (at 303/779-5455 or 1-800/654-5653) or FAX it to us (at 303/771-8657).

2000 and BEYOND

Annual Meeting Keynoter: Leanne Kaiser Carlson, MSHA

Leanne Kaiser Carlson, MSHA, an associate with Kaiser & Associates and a member of the International Health Futures Network, will be the keynote speaker at the 1996 Annual Meeting of the Colorado Medical Society. Ms. Carlson is recognized by hospitals and other healthcare organizations across the country for her state-of-the-art knowledge in health futures and the design of healthy communities.

Ms. Carlson will discuss how the flow of information is changing the face of the health care profession. She will explore how technological trends and future components will affect the individual practice of medicine, as well as physician organizations. Look for more details on this presentation, as well as the 1996 Educational Program "2000 and Beyond" in upcoming issues of *Colorado Medicine*.



CMS Annual Meeting Golf Tournament at the Sheraton Steamboat Golf Course Thursday, September 19, 1996 Entry Form

Name _____

Address _____

Please give us the following information for tee times and emergencies

Office Phone _____ Home Phone _____ FAX# _____
(necessary for reservations)

While in Steamboat I will be staying at _____

I will be attending the meeting in the capacity of (check one)

Physician Exhibitor

Spouse Other

I will: Sponsor a golf course hole @ \$100

Sponsor a putting green contest hole @ \$50

Name of sponsor (as you wish it to appear on sign)
(Professionally made signs will be displayed for sponsors)

My golf handicap is _____
I will require rental clubs @ \$25

USCGA Other
 Left handed Right handed

If you would like to play please return this entry form as soon as possible because space is limited. CMS has reserved tee times for only eight foursomes. Play will be shotgun format. Foursomes will be arranged according to various levels of ability by the golf professional. If you have a preference of who you are teamed with, please specify below. Prizes will be awarded for a variety of categories to include closest to the pin and longest drive. To ensure tournament entry, registration form and advance payment of \$90 must be received **no later than** August 30, 1995. Cancellations received after August 30, 1995 are refundable subject to ability of Sheraton Steamboat Golf Club to "resell" vacated tee times.

You will be notified regarding tee times. A shotgun start will not be possible, therefore, please be prompt with your tee times. To reserve other personal tee times, please call the Pro Shop at (970) 879-4391.

I prefer to be teamed with _____

* Mail Entry Form and check to Media Specialties, P. O. Box 36357, Denver, CO 80236. For additional information, call Tim Jackson at 303-986-5926.

Activities Available during the 1996 Annual Meeting

This information is provided by the Sheraton Steamboat Resort and the Steamboat Springs Chamber Resort Association published in the Steamboat Springs Summertime Activity Guide.

In Steamboat, you're surrounded by two million acres of National Forest and Wilderness Areas. There are over 150 mountain lakes, two major rivers, hundreds of creeks, dozens of mineral springs and two natural hot springs. Activities abound whether you're spending two hours or an entire week in Steamboat Springs. The following suggested activities will help you plan your days while taking advantage of many of the most popular things to see and do in the beautiful Yampa Valley.

What to do in Steamboat Springs:

Walk, bike or skate the winding paved trail along the Yampa River

Visit scenic Fish Creek Falls

Ride the Silver Bullet gondola up Mt. Werner to Thunderhead Peak

Float high above mountain peaks in a hot-air balloon – 1/2 and 1 hour tours \$80 to \$150 per person

Take a relaxing soak in the Strawberry Park Hot Springs – a 20 minute drive, 10 am to 12 midnight, \$5 per person

Tour the beauty of the area on horseback, daily 1 and 2 hour rides, \$30-35 per person

Learn the sport of fly fishing – \$50-85 per day, license and flies not included

Explore the ski mountain on a mountain bike – \$6 per hour, \$10 for 1/2 day and \$16 for full day

Enjoy a round of golf on a Robert Trent Jones II course while taking in Steamboat's glorious climate

Drive the Flattops Scenic Byway.

Most activities can be booked with Sheraton's Concierge staff, located in the hotel lobby, extension 1005. Prices are subject to change.

Special Events: September 21, 1996

6th Annual Steamboat Fall Foliage Festival and Brewfest – Mother Nature is the star of the Fall Foliage Festival. The aspens that surround Steamboat become the background for polka bands, kindergarten and biergarten, dancers and more festivities.

Colorado Medical Society Annual Meeting

September 19-22, 1996



Sheraton Steamboat
RESORT & CONFERENCE CENTER

*Please call direct for availability of condominiums and other types of accommodations. If reservations have already been made directly with the hotel, please do not send this card. To make reservations by mail, please complete the following. To guarantee these special rates, **reservations must be received by August 29, 1996.***

Name _____

Name(s) of additional person(s) sharing room: _____

Address _____

City _____ State _____ Zip _____ Phone () _____

Arrival date _____ Departure date _____

Please reserve the following:

Single Double Smoking Non-Smoking

Payment type

Personal check or major credit card may be used to secure deposit. First night's deposit (room only) per unit is due in our office within ten days from the date the reservation is made.

Type of card _____

Card # _____ Exp. Date _____

Name of Cardholder _____

"I authorize Sheraton Steamboat to charge my credit card for the deposit and prepayment for accommodations listed above."

Signature _____ Date _____

Children 17 and under stay for free in parent's room with existing bedding. Current sales tax is 9.5% (subject to change).

CANCELLATION POLICY: 21 or more days prior to arrival – \$25 per unit. Less than 21 days prior to arrival – Cancellations or reductions in room nights forfeit first night's deposit.

Please let us know how we may accommodate any disability or special request.

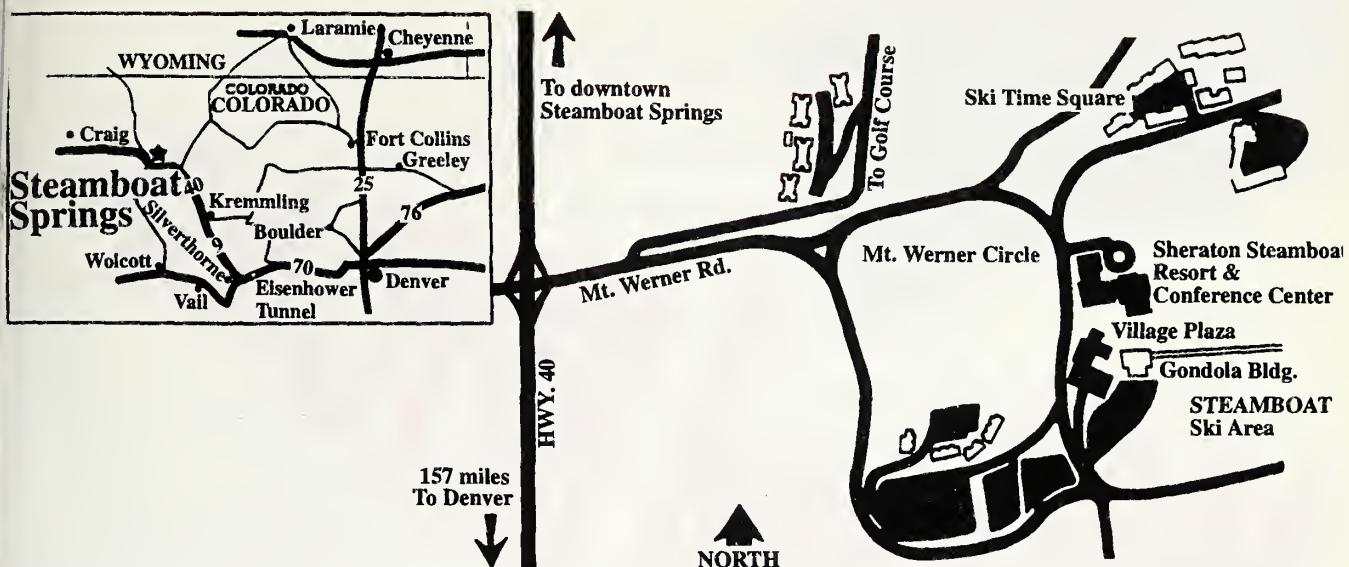
Single Rate \$89 + tax

Dbl Rate \$89 + tax

Check-in Time: 5:00 pm

Check-out Time: 11:00 am

Getting to Steamboat Springs



Copic Risk Management Seminars

FRIDAY SEPT. 20

2:15-3:15 pm	Family Practice, Internal Medicine – Dr. Thomasson	Skyline "B"
2:15-3:15 pm	General Surgery, Urology, Gynecology (no OB) – Dr. Quinn	Skyline "A"
3:45-4:45 pm	Pediatrics – Dr. Thomasson	Skyline "B"
3:45-4:45 pm	General – Dr. Quinn	Skyline "A"

CMS Seminar
"Total Wealth Management Planning"
A seminar sponsored by
The Copic Agency
1:00 p.m. Saturday - 9/21/96

The presentation will address issues regarding:

- Practice Valuation upon sale or merger
- Physician compensation / Income division alternatives
- Employment contract provisions
- Qualified vs. Nonqualified plan
- Balanced Funding Option - An Investment Strategy
- Asset Protection Planning Overview

Leon B. Harrison, CLU, with the COPIC Agency and David L. Lockwood, Attorney and principal with Engel & Rudman, P.C. will be the featured speakers.

COLORADO MEDICAL SOCIETY
and
Colorado Medical Society Alliance
Tentative 1996 Annual Meeting Schedule
Sheraton Steamboat Springs Resort and Conference Center
September 19-22, 1996
Steamboat Springs, Colorado

THURSDAY, SEPTEMBER 19

8:00 am -	CMS Office open
9:00 am -	18-hole Golf Tournament
1:00 pm -	Finance Committee
2:00 pm -	Board of Directors
4:30 pm -	Registration open
6:00 pm -	Welcome Reception
7:30 pm -	Dinner on your own

FRIDAY, SEPTEMBER 20, 1996

7:00 am -	CMS Office opens
7:00 am -	Registration
7:00 am -	Reference Committee Breakfast
7:00 am -	New Delegate Orientation Breakfast
7:00 am -	AMA Delegation Forum Breakfast
8:00 am -	12:00 N
7:45 am -	Exhibits open
8:00 am -	8:00 am
8:00 am -	Credentials Committee
8:30 am -	8:30 am
8:30 am -	Opening Session House of Delegates
8:30 am -	Alliance Board
8:30 am -	12:00 N
9:30 am -	General Membership Meeting
9:45 am -	Coffee break
9:45 am -	Alliance General Meeting
12:15 pm -	11:45 am
12:15 pm -	COMPAC/CMSA Luncheon
2:00 pm -	1:45 pm
2:00 pm -	Alliance Workshop
2:15 pm -	3:00 pm
2:15 pm -	Army National Guard Physicians
2:15 pm -	Copic Risk Management
2:30 pm -	3:15 pm
2:30 pm -	Copic Risk Management
3:00 pm -	4:30 pm
3:30 pm -	Reference Committee
3:45 pm -	Alliance County Breakout Sessions
3:45 pm -	Reference Committee
3:45 pm -	Copic Risk Management
3:45 pm -	Copic Risk Management

NOTE: Dress for Annual Meeting

Thursday evening reception:	any style from 1871 to present
Friday:	casual
Saturday morning:	casual
Saturday inaugural dinner/dance:	casual or "futuristic"
Sunday:	casual

FRIDAY, SEPTEMBER 20 (CONTINUED)

4:00 pm –	7:00 pm	Exhibits open
5:30 pm –	7:00 pm	Exhibitor Reception
6:30 pm –	8:00 pm	Women in Medicine Dinner and Business Meeting
6:30 pm –	7:30 pm	Colorado Society of Internal Medicine Annual Meeting
7:00 pm –	9:00 pm	Gone But Not Forgotten Dinner (by invitation only)

SATURDAY, SEPTEMBER 21

7:00 am -		CMS Office opens
7:00 am -	11:00 am	Registration
7:00 am -	7:50 am	Educational Program Continental Breakfast
7:00 am -	11:00 am	Exhibits open
8:00 am -	12:00 N	Educational Program
9:00 am -	11:00 am	Alliance Meeting
12:00 N -		Recreation Time - golf, tennis, horseback riding, biking, fishing, walking, etc.
12:15 pm -	2:45 pm	COMPAC Political Campaign Seminar (Lunch)
1:00 pm -	4:00 pm	Copic Seminar
1:00 pm -	4:00 pm	Army National Guard Physicians
6:00 pm -	6:15 pm	Cocktails - cash bar
6:15 pm -	7:00 pm	Inaugural
7:00 pm -	10:30 pm	Presidents' Dinner/Dance
9:30 pm -	11:00 pm	Copic Dessert Reception

SUNDAY, SEPTEMBER 22

6:30 am –		Reference Committee Reports available
7:00 am –		CMS Office opens
7:00 am –	10:00 am	Registration
7:00 am –	8:30 am	Component Caucuses
	Arapahoe	Denver
	Aurora-Adams	El Paso
	Boulder	Larimer/Weld
	Clear Creek Valley	Pueblo/Western Slope
8:00 am –	8:30 am	Credentials Committee
8:30 am –	12:00 N	Closing Session HOD
9:00 am –	10:00 am	CMSA Gavel Club Breakfast
12:00 N (or immediately following HOD)		Nominating Committee
12:00 N (or immediately following HOD)		Reorganizational Board



NEW MEMBERS

Congratulations and welcome to these physicians who have been recently elected to membership in the Colorado Medical Society.

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Julie A Parsons, MD
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Branka Milos, MD

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Cyrus Ghavam, MD
Eva P Gill, MD
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AMA UPDATE

by Richert E. Quinn, MD
Senior AMA Delegate



"Physicians seem to actually be appreciating the need for unity . . ."

The 1996 AMA Annual Meeting was, in general, less contentious than most recent gatherings. Physicians seem to actually be appreciating the need for unity and, while controversial issues were debated at length, the disparate specialty and organizational representatives seemed more willing to support the rule of the "whole" than in the past. The recommendations of the Federation Study were approved in their entirety, increasing the representation of the specialty societies in the House of Delegates dramatically. Physicians who belong to the AMA will henceforth designate one specialty society to represent their interests and will continue to be represented by their state delegation. The number of specialty delegates will depend on that ballot. Hopefully, better collaboration among medical organizations will result. Other changes designed to increase participation aimed at inclusivity concerning gender, mode of practice, ethnicity, and international medical graduates are on the drawing board, as are changes in the structure and function of the AMA Board.

As one example of the spirit of conciliation pervading the meeting, surgeons and primary care physicians compromised and arrived at a formula for transition to a single Medicare conversion factor. There was also agreement to postpone implementation of new practice expense RVU's (Relative Value Units) for one year, giving Health Care Financing Administration (HCFA) time to derive sound data.

Extensive debate over physician-

assisted suicide attracted national media attention. Ultimately, the House took an uncompromising stand against the practice, at the same time calling attention to the need for increased efforts to educate physicians about pain control and other needs of terminal patients.

Managed care was the subject of numerous resolutions and reports. The flavor has changed from one of preventing its proliferation to a sense of guiding its development to preserve the essence of medical practice while ensuring that the outcomes it produces are in the best interests of patients and physicians. The importance of the relationship between these two parties was recognized by the House in the ratification of the **Patient-Physician Covenant**, which states:

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimization of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, carer, helper,

(Continued next page)

and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gatekeepers, or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state, and local professional societies; our academic, research, and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend, and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients.

Ratification of the Patient-Physician Covenant by the House should help physicians separate the ethics of medicine from the ethics of business; the latter considers physicians as competitors and their services as commodities while patients become consumers and market forces can replace peer review as a means of quality management.

Colorado presented two resolutions; one concerned better communications to physicians by the AMA and the other called for creation of a model state resolution patterned after Colo. 96-11 concerning equitable tax treatment of health care expenditures. Both were well received and incorporated into AMA policy.

Your alternate delegates are Bob McCartney, Rob Bogin and Joel Karlin, and your delegates are Ray

Painter, Mark Levine and me. Dick Allen of the OB society and Gene Jacobson from the GI group are functionally part of our delegation, participating in all our activities before, during, and after the AMA House. Both are strong, participatory CMS members. Despite our support, Gene failed to be elected to the Council on Scientific Affairs, but he made a strong showing. We continue to collaborate with the other Rocky Mountain States whose interests are remarkably similar to ours. Colorado is well thought of at the AMA: when we speak they are much more prone to listen than in the past. **We need more input from CMS members.** At the CMS Annual Meeting, there will be a forum for your input.

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Telemedicine: Pocketbooks, multi-state migraines and thorny risks

by **Richert E. Quinn, M.D.**
Physician Risk Manager
Copic Insurance Company

"The price conscious motivation of managed care and the entrepreneurial pursuits of some providers have joined this sophisticated consultation race to create reimbursement issues, controversy regarding licensure and concerns about professional liability in telemedicine."

The promise of telemedicine and its potential to increase access to cost effective, efficient health care seems to grow daily. The interest and implementation of telemedicine technologies has surged with improved electronic transfer capabilities. Rural networks have sprung up all over the nation that utilize images and information of a quality heretofore thought impossible.

The price conscious motivation of managed care and the entrepreneurial pursuits of some providers have joined this sophisticated consultation race to create reimbursement issues, controversy regarding licensure and concerns about professional liability in telemedicine. While they represent only a facet of the larger debate surrounding telemedicine, reimbursement, licensure and liability are all interconnected and must be understood before other issues in the overall debate can be addressed.

Current reimbursement policies for telemedicine are described as limited and inconsistent. The reason for this confusion stems from the fact that no definitive studies have verified both the costs and effectiveness of telemedicine services. The private sector cautiously waits for federal and state laws to be passed, while benefit regulatory agencies like the Health Care Financing Administration (HCFA) ponder if telemedicine is truly safe. In the absence of national/state policy and reliable sources of revenue, regional offices and networks must depend on federal, state and private grants to fund telemedicine projects. Some advances have been made. How-

ever, the telemedicine policy vacuum continues to deter physicians from participating because of fears of not being paid for services rendered.

The same type of hesitation and confusion holds true for licensure. This controversy centers around a more easily obtained license for limited practice (as recommended by the Federation of State Medical Boards), versus requiring full licensure in each and every state where telemedicine patients are located. (There seems to be general consensus that the practice of medicine "legally" occurs where the patient is located). The latter view has been espoused by some specialty boards, and most recently by the AMA House of Delegates.

The licensure debate attempts to address quality and regulatory issues. However, practitioners are hesitant to use multi-state telemedicine networks because of the costs/administrative headaches associated with multiple licenses. There are those who argue that requiring the expense and paperwork of full licensure in multiple states will hasten the day of a single national licensure process.

The professional liability issues raised by telemedicine may prove to be the thorniest of all. The quality and reliability of transmissions raise malpractice concerns regarding completeness. Moreover, dissension continues to uproot conclusions regarding whether or not this remote media effectively changes the "face to face" nature of medical practice. Professional liability carriers are

(Continued next page)

oncerned about defending legal actions in states where the legal ground rules may differ significantly from the home state, where actuarial rate determinations are based on an "in-state" experience.

All of these issues are intricately intertwined. Some experts believe that liability laws have yet to be tested because of lack of reimbursement and licensure laws. Some dispute the allegation that multi-state consultations can be construed as interstate commerce subject to Federal Trade Commission regulation. There are those that disagree on the definition of "consulting physician" and its ramifications on payment, while still other experts debate whether the doctrine of "sovereign immunity" protects providers from liability for "remote" indigent care.

Nonetheless these are all issues that have to be addressed. They undoubtedly will as telemedicine continues to advance thanks to better technology, cheaper transmission rates, widening markets driven by managed care and other competitive phenomena, and increased demand in rural areas. Federal and state agencies are diligently evaluating programs. HCFA is working on a national Medicare policy, and it currently allows state Medicaid agencies to set their own coverage policies for telemedicine. One can certainly appreciate the pros and cons of these wonderful technologies. It is the responsibility of our profession to see that they are ultimately used for our patients' benefit, in terms of cost, access and quality. Telemedicine's impact on those issues will be explored next month.

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BACK IN HEALTH - Multidisciplinary clinic seeks doctor to share space, and employee in DTC. Orchard and Holly. Beautiful office. Nice people. Please call (303) 770-4424. 06/0896


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Call R.K. Brainard Owner
(970) 474-2650

03/0796



Have you sent in your membership dues for COMPAC-1996? If you have paid any attention to politics this first seven months, you will already know that this could be a major pivotal year for medical practice in Colorado. The state legislature will have a lot to say about your practice in coming years by what they pass into law this year. Your membership in COMPAC will help elect those legislators who are supportive of physician issues. Join COMPAC today!

\$150 1996 Election Fund

\$100 Sustaining Member

\$15 Resident Member

\$5 Student Member

Make your personal check payable to: COMPAC. Send it along with your name, address, zip code and phone number to P.O. Box 17550, Denver, CO 80217-0550

1996 FAMILY PRACTICE OPPORTUNITIES FAIR

September 6-8 at Copper Mountain Resort

A relaxed, educational and fun setting to meet the State's second and third year Family Practice Residents.

An opportunity to recruit well-trained, enthusiastic Family Practice Physicians and their families!

A recruitment event without the "we" "they" environment.

An excellent rate of return on your investment: 60% of the participants at the **1995 Opportunities Fair** recruited at least one Family Practice Resident - all 1996 graduates.

Five Family Practice Residents were recruited for a rural community!

For additional information contact Commission on Family Medicine: 2851 South Parker Road, Aurora, Co 80014, (303) 745-4275.



The **C**hoice Choice Is *Theirs*

A video for physicians on Advance Medical Directives making End-of-Life Decisions

Are physicians well-informed and knowledgeable about Advance Medical Directives? Patients think they are, but some surveys indicate that many physicians don't know or understand current laws. *The Choice Is Theirs* video is specifically designed to walk the physician and his/her staff through the laws and their many features.

In an effort to assist the medical community and the public with questions on Advance Medical Directives, a consortium was formed. The goal of this group is to help educate all involved about these personal issues. The consortium includes: the Colorado Springs Osteopathic Foundation, Memorial Hospital, the Penrose-St. Francis Healthcare System, the Colorado Hospice Organization and Gonzaga University Television.

The Choice Is Theirs, a video about advance medical directives in the State of Colorado, (Living Wills, Medical Durable Power of Attorney and CPR Directives - Cardiopulmonary Resuscitation Directive) features Colorado and national experts from the legal, medical and medical ethic communities who answer the following questions:

1. What are advance medical directives as described in Colorado law?
2. What do these documents do for the patient and for the doctor?
3. When should advance directives be discussed with patients and families?
4. Who should have advance directives?
5. Where can the appropriate documents be obtained?

The Choice Is Theirs will be extremely helpful to the doctor, medical office staff, healthcare professionals, nursing educators, attorneys, and others. The video is a companion to **"The Choice Is Yours"**, a video produced for the general public, patients and their families. **The two videos complement each other, one directed to physicians and the other to the public/patient/families.**

To order your copy of ***The Choice Is Theirs***, fill out the following order blank. Allow up to four weeks for delivery.

Name _____ Phone () _____

Address _____

Number of videos ordered _____ (\$25.00 each, including postage & handling) **Total \$** _____

MAKE CHECK OR MONEY ORDER PAYABLE TO: Colorado Springs Osteopathic Foundation (719) 635-9057
(MEMO: Advance Directive Video)

MAIL ORDER FORM AND PAYMENT TO:

The Choice Is Theirs (Video for Physicians)
Health Resource Center
The Penrose-St. Francis Healthcare System
P. O. Box 7021
Colorado Springs, Colorado 80933



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

"When I was born I certainly wasn't expected to live this long!"

Another Annual Meeting! Not just another annual meeting though. This one has a forward look about it, trying to look around the corner at the turn-of-the-century.

I remember going with my father to the airport to see the first scheduled commercial airliner to arrive (it was a Ford tri-motor). I can't even imagine what was going through my mind at the time, but I know it had nothing to do with the turn-of-the-century. I **can** remember, not long after that, when the neighbor boy threw a half of a large whetstone (the piece was about 7 inches long by 2 inches square). It was memorable because I was standing under it as it neared the ground and I suffered a large puncture wound in the head. It was also memorable because I had to be treated quickly. Someone called the doctor and told him it was an emergency, and he came to my house and treated me right there. I can still feel the doctor's swab as he cleansed the laceration (after I regained consciousness), looking for the fracture. It was only a small fracture because the stone hit me a glancing blow. (As I looked up and realized I was about to be struck I twisted my head away from the missile's path, but not quite fast enough.) I can remember feeling the swab rummaging around my

skull bone.

Often, I have thought that my whole life has been one big glancing blow to the head. That seems to be the way my brain has operated, absorbing only a percentage of the information which assaults it because I allow it to strike only a glancing blow.

Another thing I can remember from those many years back is how medical care has changed. That's not a fair statement for me to make, however, because where I was born there wasn't anything but house calls in Model T's, and if you were hospitalized it would have to be down in the city. Fortunately, I never was.

I'll never forget my mother (when she was 96 and living in Denver) when we hospitalized her to have a hip joint replaced. During the informed consent, the doctor asked her "When was the last time you were in the hospital?" She said "This is the first time!" After he recaptured his composure, the doctor asked "When was the last time you saw a doctor?" She replied "Well, it was before you were born." I knew the doctor's age, so I knew how long ago that had been.

Now me, I was born at home, and the doctor who delivered me (according to the story my mother told me) asked her, after I arrived, "What are you going to name him?" Well, she hadn't decided, so the doctor said "Why don't you name him after your father?" And she did.

Gosh, things were simple!

Now, we're looking into a new century—a new age: **2000 and Beyond**. And what will medical practice or "doctoring", as it used to be called, be like? That's what our meeting is about. That's what every meeting is about: "What will doctoring be like in the next new age?" It has changed a lot in the time I've been watching these meetings, and it has REALLY changed since I was a pup. But you wouldn't like it if it hadn't changed or tried to keep up with the changing needs of the people you serve.

Medical practice will be with us for a long time to come, and it will still be the finest profession in all mankind. But it is up to the practicing physicians to help maintain medical practice and adapt to changing needs, not just fight change.

That's certainly what organized medicine and annual meetings are about! They both help protect the communications among peer professionals and allied health care providers; they help protect and foster the collegiality; they attempt to provide a look into the future and prepare the physicians for the next "new age".

This is not just another annual meeting; this will be Colorado Medical Society's 126th Annual Meeting. Without organized medicine and all its meetings, medical practice would be far more different than what we know.

When I was born I certainly wasn't expected to live **this** long. I'm very happy to be able to see another annual meeting.



Joel M. Karlin, MD
President, 1995-1996



Almost two years ago you bestowed upon me the greatest honor and responsibility by electing me President-elect of the Colorado Medical Society. I wanted the job because I felt that the potential we had as physicians to take back control of our health care delivery system was enormous...to redirect the focus back to doing what is best for our patients. And I wanted to be an integral part of that movement!

In my speech to the CMS House of Delegates last September, I shared with you my personal feelings regarding the **doctor-patient relationship**... first from the perspective of a patient whose family doctor had taught me what was good about medicine, and then through the eyes of a physician who cherishes that bond with his patients of caring, trust, mutual respect, and emotional support.

During this year of my presidency, we have focused on patient oriented issues, and giving Colorado physicians the opportunity to provide the care their patients need. We have focused on being the spokesperson for our profession while at the same time advocating for the best interests of our patients.

Almost all of us have experienced that feeling of helplessness when confronted by a long-time patient whose employer had just changed health plans to one in which we did not participate. What can you say to the mother of that child whose life you had helped to reshape for the better? She doesn't understand why you cannot continue to be her child's doctor. Several Colorado HMOs have

decided over the last several years that a limited physician panel is in their best interest. It appeared that little thought went into early decisions on such "downsizing". Colorado Medical Society worked collaboratively with the Colorado HMO Association for over a year in developing "The White Paper on Physician Affiliation/Disaffiliation". I am happy to report that a preponderance of Colorado HMOs have signed the "White Paper", and today, "termination without cause" is not taken lightly. We are currently working with physician organizations to implement the "White Paper" principles. Our Joint CMS/CHMOA Committee has met regularly and I have appreciated the commitment of all committee members to tackle important issues such as confidentiality of medical records, continuity of care when transferring from one health plan to another, and maternal lengths of stay. We are fortunate to work with such dedicated and cooperative members of the Colorado HMO Association.

This year we created a Managed Care Task Force to assist physicians with difficult problems encountered while practicing in the managed care environment. This Task Force brought forth the issue of "gag clauses" in certain physician contracts which led to the CMS written, sponsored and successfully passed HB-1216 which prohibits their existence. It tackled the difficult issues of controlled access to specialty care, in-office physician evaluations, and HMO formularies. Resolutions from the Task Force will be considered at our Annual Meeting.

... 'termination without cause' is not taken lightly.'

In our proactive posture, the Health System Reform Committee tackled the important issues of Medicare and Medicaid. They developed principles which should be included in any sweeping changes in these two publicly funded programs and will serve us well as we continue to engage in future dialogue.

Your CMS Data Committee has worked hard to put us at the table as data issues are discussed in Colorado. I know you will be excited with the quality initiative they are developing with the purchasers of health care in our state.

CMS heard the cry from our rural members who so badly needed help in recruiting new physicians to and retaining current physicians to practice in their communities. We wrote a loan forgiveness bill for the Colorado Legislature, only to see it fail for lack of funding. Rather than to accept defeat, CMS has undertaken to create and administer this program ourselves.

(Continued on following page)

PRESIDENT'S LETTER

(Continued from preceding page)

Colorado has gained national attention with new and innovative programs designed to put our patients' interests first. Colorado Physicians Network has worked with Rocky Mountain HMO in creating Colorado Physician Choice Plan. Developing the next generation of managed care where primary care and specialty physicians work together to provide a continuum of care, our physician sponsored plan has the opportunity to set the standard by which other health plans will have to compete in this marketplace. Already, one hospital is looking at moving to a more physician inclusive PHO, while one health plan is exploring the sale of a substantial ownership interest to physicians "to bring them to the table as equals". By late this fall, CPN member physicians will begin seeing patients throughout the state. Other states have recognized our bold move, and are exploring development of their own statewide physician controlled managed care entities.

But in the end, we must put the control of the selection and ownership of health insurance into the hands of the individual. In such a system, accountability of health plans will be directed towards the patient, not only on the basis of cost, but also on the basis of quality and access. Increasing costs will be controlled by competitive market forces. As Dr. Stormy Johnson, AMA President said in his inaugural address recently, "It is time we realized that people are not so stupid that such a choice is beyond their capabilities." To make good choices, it will be necessary to provide individuals with more standardized information about health plans and physicians. In order to take the first step in providing patients with information about their physicians, this year CMS undertook the Colorado Physician Profiling Project. Cosponsored by COPIC and Gadian, CMS physician members can voluntarily provide validated information about themselves to patients. The CMS Patient Advisory Committee is developing an educational piece for consumers which will run as a newspaper supplement.

Thirty-eight percent of commercially insured Coloradans have only one plan from which to select. We

must accept the fact that one delivery system, let alone one health plan, does not work for everyone. CMS has taken the issue to our state legislature where Senate Joint Resolution 11 put the Colorado Legislature on record of supporting changes in the tax treatment of health insurance contributions which could enable such a system transformation. Additionally, we have interested Congressional leadership in our proposal, and are working with several other states to move our AMA to a position solidly behind us.

I will leave office later this month knowing that CMS will be in excellent hands under the direction of your incoming President, Dr. Ray Painter. Many of the projects and directions started these last two years will be refined and pursued by your new leadership. Through the efforts of many of you who have helped so much this year, as well as the superb CMS staff under the capable direction of our Executive Director Sandi Maloney, I know that we have helped to push the pendulum of health care back in the right direction.. doing what is best for our patients. Thank you for your help and your support, and the honor to have served you.

Have you sent in your membership dues for COMPAC-1996? If you have paid any attention to politics this first eight months, you will already know that this could be a major pivotal year for medical practice in Colorado. The state legislature will have a lot to say about your practice in coming years by what they pass into law in 1997 and beyond. Your membership in COMPAC will help elect those legislators who are supportive of physician issues.

- \$150 1996 Election Fund
- \$15 Resident Member



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tors who are supportive of phy-
Join COMPAC today!

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Make your personal check payable to: COMPAC. Send it along with your name, address zip code and phone number to P.O. Box 17550, Denver, CO 80217-0550

CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax[®]

by Montgomery Little and McGrew, P.C.

legal counsel to the Colorado Medical Society

1996 CMS President-elect race —

The candidates announce their intentions

The election of 1996-97 CMS President-elect will take place this month during the Annual Meeting in Steamboat Springs. The two candidates, Dr. Thomas J. Allen and Dr. Gary D. VanderArk, were asked to give a brief description of their intentions to run for the president-elect position. Dr. VanderArk declared his candidacy in April and Dr. Allen did the same in late July. Both candidates provide statements below, however, because of scheduling complications Dr. Allen's comments are much briefer than Dr. VanderArk's. Delegates, please look for further details in your Annual Meeting Delegate's Handbook.

Thomas J. Allen, MD



As physicians of the 1990's, we find ourselves in a climate of unprecedented economic stress and turmoil. Our loyalties and professional efforts are divided among our traditional medical organizations and a smorgasbord of new economic and professional alliances. Third parties increasingly dictate how we should practice medicine. The Medicare and Medicaid systems are on a crash course toward the "brick wall" of the aging baby-boom generation. Through our Colorado Medical Society, its components and the American Medical Association, physicians can honor their Hippocratic Oath and attempt to preserve the values and traditions of the medical profession. I believe in these values, and hope that my leadership experiences in organized medicine over the last twenty years have prepared me for further contributions as president-elect of CMS.

Gary D. VanderArk, MD



It seems to me that the greatest need of the physicians in Colorado is to establish a new sense of unity. To that end, the primary role of the CMS president must be that of negotiator. The negotiator's job falls into three main categories: organization, legislation and managed care. You need to elect that person who will best represent the house of medicine at these conference tables.

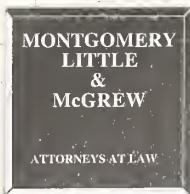
Medicine is suffering under the bondage of managed care. We need a negotiator who produces compromise but not appeasement. We cannot abandon ethical managed care. We must hold fast in our role as both physician and patient advocate.

CMS must speak for medicine in Colorado as a unified voice. To achieve this unity of physicians, we need to include those in academia and those in managed care organizations.

CMS has enjoyed a great year under the leadership of Joel Karlin and Dick Allen in the legislative area. However, our past history must serve only as the platform for a new level of accomplishment. It is not enough to have Joel and Dick involved. We must mobilize the entire membership of CMS to speak up for our principles and our patients.

So if the chief need of the CMS is for a negotiation leader and if the greatest need of the physicians in Colorado is to establish a new sense of unity, why should you elect Gary VanderArk? The answer must be based on a demonstrated track record. I have had my card punched at all of the right stations: elected leader in medical organizations (President of Combined Medical Staff of Porter/Swedish Hospitals, President of the Arapahoe Medical Society, President of Colorado Neurological Society), involvement with CMS at all levels (delegate, board of directors, task forces, committees), and executive in health care ventures (CEO of Colorado Neurological Institute, Doctors Care, Neurocare IPA).

Times of great difficulty are times of great opportunity. I am running for the presidency of CMS because these are times of important change. I can serve the physicians of Colorado in making those changes positive to the way we practice medicine.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Recent Legislation

The following bills were passed during the most recent legislative session. The descriptions, which were prepared by Rachel Avery and Michael Baldez for the Colorado Bar Association, are not comprehensive, but are intended to alert you to the existence of new legislation which may affect your practice or patients.

HB 1237 – Concerning a Mandatory Waiting Period Before Any Person May Solicit an Accident Victim

Prohibits any person from soliciting employment relating to personal injury or wrongful death for 30 days following an accident. Prohibits any person from accepting referrals of employment relating to personal injury or wrongful death from anyone who solicited a person within 30 days of an accident. Allows the individual suffering the injury or the individual's authorized representative to void any agreement made within the 30-day period. Defines "solicitation" as any communication directed to a specific individual, but excludes from the definition advertisements in newspapers or yellow pages and on television or radio. Enlarges from 15 days to 30 days the period of time after an injury during which a person adverse to an injured party may not engage in negotiations for a settlement or release, but retains the period at 15 days during which a person adverse may not obtain a statement from an injured party. Effective 7-1-96.

SB 229 – Concerning Involuntary Medication for the Mentally Ill

Expands the statute permitting a court to enter an order requiring a person to accept medication to include persons found not guilty by reason of insanity or impaired mental condition and persons found incompetent to proceed. Requires a court to appoint an attorney to represent such persons. Effective 5-23-96.

SB 025 – Concerning Health Care Coverage Cooperatives

Eliminates the requirement that health care coverage cooperative be operated on a not-for-profit basis. Effective 5-23-96.

HB 1264 – Concerning Health Care Cooperative Purchasing Arrangements

Adds definitions to the statutes governing health care coverage cooperatives to make the provisions consistent with the laws regulating small group health insurance. Allows health insurance entities offering coverage through a waivered health care coverage cooperative to offer certain standardized coverages and specially negotiated rates only to cooperative members and not to others outside the cooperative. Effective 5-23-96.

HB 1082 – Concerning Coverage Under a Health Benefit Plan of Health Care Services Related to a Woman's Reproductive System Provided by Participating Physicians Who Routinely Practice Women's Reproductive System Health Care

Defines "Health Coverage Plans" and "Managed Care Plans." Effective 1-31-97, a managed care plan that provides coverage for reproductive health or gynecological care can only be issued or renewed if the plan: provides a woman covered by the plan direct access to an obstetrician or gynecologist participating and available under the plan for her reproductive health care or gynecological care; or has procedures that ensure that, if a woman covered by the plan requests a timely referral to an obstetrician or gynecologist, participating and available under the plan for her reproductive health and gynecological care, the request for referral shall not be unreasonably withheld. Applies to health coverage plans issued or renewed on or after 1-31-97. Effective 7-1-96.

CMS Med Fax

FTC-sponsored Health Care Antitrust Conference to be held in Denver

The Denver Regional Office of the Federal Trade Commission (FTC) is sponsoring a Health Care Antitrust Conference on Friday, October 25, from 8 AM to 5 PM at the Embassy Suites in downtown Denver. The conference is open to health care antitrust attorneys, physicians, managed care providers, hospital administrators and other managers in the health care field. Topics that will be discussed in the conference include the antitrust implications of the vertical integration of hospitals and physicians; the role of private antitrust counsel in health care antitrust enforcement; the impact of competition in health care delivery; the new FTC/DOJ Health Care Guidelines; and hospital merger analysis in recent litigated antitrust cases.

Featured speakers:

- FTC Commissioner Roscoe B. Starek;
- Mark D. Whitener, Deputy Director for the FTC's Bureau of Competition;
- Dr. Malik Hasan, Founder, Chairman and CEO of Health Systems International;
- Larry Wall, President, Colorado Hospital Association;
- Mark Donohue, Executive Director of Prudential Health Care and President of the Colorado HMO Association.

Cost: \$75 (includes breakfast and lunch).

Registration: contact FTC Attorney Pam Cole at (303) 844-2255 or complete application on next page.

Registration deadline: October 11, 1996.

FTC Antitrust Health Care Conference Downtown Embassy Suites Hotel October 25, 1996; 8:00 AM to 5:00 PM

AGENDA

8:00 - 8:45 am	Registration
8:45 - 9:00 am	Welcoming remarks from Claude C. Wild, III, Denver Regional Director, Federal Trade Commission
9:00 - 10:30 am	Antitrust, Economic and Health Care Implications of Vertical Integration between Hospitals and Physicians <ul style="list-style-type: none">• Hospital perspective – (Columbia/HealthONE)• Managed care perspective – Mark Donohue, MD, Executive Director, Prudential Health Care and President, Colorado HMO Association• Physician perspective – Leigh Truitt, MD, Publisher of the <u>Rocky Mountain Health Care Observer</u>• Antitrust enforcement perspective – (DOJ Attorney to be announced) <i>Moderator</i> – James R. Hertel, Publisher, <u>Colorado Managed Care</u>
10:45 - 11:00 am	Break
11:00 - Noon	The New FTC/DOJ Health Care Guidelines <ul style="list-style-type: none">• Mark D. Whitener, Deputy Director, Bureau of Competition, Federal Trade Commission
Noon-1:30 pm	Luncheon speaker: Commissioner Roscoe B. Starek, FTC

1:30 - 3:00 pm	The Role of Competition in Health Care Delivery <ul style="list-style-type: none">• Managed care perspective - Dr. Malik Hasan, Founder, Chairman and CEO of Health Systems Int.• Hospitals' perspective - Larry Wall, President, Colorado Hospital Association• Economist's perspective - Lawrence Wu, Senior Analyst, National Economic Research Associates <i>Moderator</i> - Jan Zavislans, First Assistant Attorney General, Colorado Attorney General's Office
3:00 - 3:15 pm	Break
3:15 - 4:15 pm	The Role of Private Antitrust Counsel in Private Health Care Antitrust Enforcement <ul style="list-style-type: none">• Don Lewis, Attorney, Verner, Liipfert, Bernhard, McPerson & Hand, Washington, D.C.• Jim Hartley, Attorney, Holland & Hart, Denver, Co.• Gale Miller, Attorney, Davis, Graham & Stubbs• Norris E. Washington, Staff Attorney, FTC, <i>Denver Regional Office</i> <i>Moderator</i> - Tom McMahon, Attorney Musgrave & Theis
4:15 - 5:00 pm	Hospital Merger Analysis and Recent Litigated Hospital Antitrust Cases <ul style="list-style-type: none">• William G. Kopit, Epstein, Becker & Green, PC, Washington, D.C.• Pamela Cole, Staff Attorney, FTC, Denver Reg. Office <i>Moderator</i> - Elizabeth Palmquist, Staff Attorney, FTC, Denver Regional Office

CMS Med Fax

FEDERAL TRADE COMMISSION HEALTH CARE ANTITRUST CONFERENCE (ANTITRUST DEVELOPMENTS AND NEW HEALTH CARE ARRANGEMENTS)

October 25, 1996, 8 AM - 5 PM
Embassy Suites Hotel – Downtown Denver
Conference Registration \$75

REGISTRATION FORM

This conference is designed to aid practitioners, physicians and health care managers plan and understand the relationship and implications of new health care arrangements and antitrust law.

FEATURED SPEAKER — FTC Commissioner Roscoe B. Starek

- Antitrust Implications of the Vertical Integration of Hospitals and Physicians
- The Role of Private Antitrust Counsel in Health Care Antitrust Enforcement
- The Impact of Competition in Health Care Delivery
- The New FTC/DOJ Health Care Guidelines
- Hospital Merger Analysis in Recent Litigated Antitrust Cases

REGISTRATION DEADLINE OCTOBER 11, 1996

FTC Health Care Antitrust Conference registration \$75

Name _____

Organization or firm _____ Title _____

Address _____

City _____ State _____ Zip _____

Telephone number _____ Fax number _____

Make checks payable to *Jan Huff, Cashier*.

For questions about the conference call Pam Cole at (303) 844-2255.

CLE credit applied for.

Please mail this completed registration form with check to:

Federal Trade Commission
1961 Stout Street, Suite 1523
Denver, Colorado 80294-0101

CMS initiates domestic violence research project

The Colorado Medical Society is working with local residency programs to replicate a Minnesota Medical Association study on physician detection of family violence. The purpose of this simple study is to ascertain whether physicians wearing buttons with an anti-abuse message ("Talk to me about family violence and abuse") have more conversations about violence than physicians not wearing such buttons. Results of the Minnesota study found that wearing the buttons significantly increased conversations about family violence and makes physicians more consistent in talking about violence with patients.

The internal medicine residency program at St. Joseph's Hospital is in the middle of a one month pilot study to fine tune the study protocols. Thanks to Drs. Robert Gibbons, Kelly O'Brien-Falls and Camille Wright for their willingness and enthusiasm in pursuing this project. The study will then be expanded to include the general surgery, family practice and OB/GYN residency programs at St. Joseph's. The other residency programs throughout Colorado are also considering participating in the study. Study results will be published in *Colorado Medicine* and assuming results similar to those in Minnesota, the buttons will be available to CMS members through the Colorado Medical Society.

This study is part of the ongoing efforts of CMS to provide tools to physicians to assist them in better responding to their patients who are involved in domestic violence. For more information or resource materials, please call Ellen Stein at the Colorado Medical Society (930-0414 or 1-800-654-5653).

CFMC Annual CME Meeting

The Colorado Foundation for Medical Care (CFMC) will be sponsoring a continuing medical education (CME) conference on October 16 at the Embassy Suites Denver Southeast at 7525 East Hampden Avenue. The purpose and objective of this presentation is to inform and educate physicians, health care quality improvement personnel, health plans, hospital management, health plan management leaders and other interested individuals in this outcome measure. Two nationally known experts in quality health care will present an interactive medical education program centered on "Patient-Based Assessment." Dr. John Ware is a Senior Scientist at the Health Institute at New England Medical Center, a Research Professor in the Department of Psychiatry at Tufts School of Medicine, and is an Adjunct Professor in Public Health at Harvard University. Since 1984, he has served as Principal Investigator for Medical Outcomes Study, which developed the SF-36 Health Survey and other widely used, patent-based outcomes measures. Dr. Marcia Stevic is one of the pioneers in the integration of outcomes measurement and clinical practice guidelines into clinical practice. Formerly Director of Quality Research at the Cleveland Clinic, she joined the Health Services Advisory Group (HSAG) in Phoenix in 1995, where she is responsible for the design and management of various quality improvement projects, including diabetes, low back pain and CHF. As an independent consultant, she works with managed care organization in implementing guidelines into credentialing, reimbursement and case management programs. Call Mary Fletcher at CFMC (303) 695-3300, Ext. 3005 for additional information.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

University of Colorado's CME in the Rockies

Rky. Mtn. Correctional Health Care Conference
October 1996
Denver, Colorado
(303) 372-9050 or 1-800-882-9153

Colorado Hospital Association

17th Annual Statewide Trustee Conference
October 3-5, 1996
Lakewood, Colorado
(303) 758-1630

Colorado Physicians

Managing Managed Care 1996
October 5, 1996
Denver, Colorado
(303) 674-8581

Colorado Hospital Association

Restraints and Seclusion: Addressing the Issues/
Complying with Standards
October 7, 1996
Lakewood, Colorado
(303) 758-1630

Colorado Hospital Association

Performance Improvement Standards in Home Care
Organizations
October 10-11, 1996
Denver, Colorado
(303) 758-1630

Colorado Foundation for Medical Care

CFMC Annual CME Meeting
October 16, 1996
Denver, Colorado
Contact: Mary Fletcher at (303) 695-3300, Ext.3005

Denver Reg. Office of the FTC

FTC Health Care Antitrust Conference
October 25, 1996
Denver, Colorado
Contact: Pam Cole at (303) 844-2255

University of Colorado's CME in the Rockies

42nd Family Practice Review
October 28-November 1, 1996
UCHSC, Denver, Colorado
(303) 372-9050 or 1-800-882-9153

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
November 7-8, 1996
Englewood, Colorado
(303) 397-7876

HIV Clinical Training Program

Col. AIDS Educ. & Training Center and UCHSC
November 13-15, 1996
Denver, Colorado
(303) 355-1305

International Meniere's Disease Research Institute

8th Annual Seminar and Workshops: Diagnostic and
Rehabilitative Aspects of Dizziness and
Balance Disorders
December 4-7, 1996
Denver, Colorado

Contact: Jane Wells, (303) 788-4235

Colorado Hospital Association

Accreditation Standards for Hospital-Based Ambulatory
Care Services
December 5-6, 1996
Denver, Colorado
(303) 758- 1630

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
December 5-6, 1996
Englewood, Colorado
(303) 397-7876

University of Colorado's CME in the Rockies

5th Update on Infectious Disease:
Bugs and Drugs in the 90's
December 6-7, 1996
Denver, Colorado
(303) 372-9050 or 1-800-8820-9153



LEGAL UPDATE

Notice Requirement

One recent case decided by the Colorado Appellate Court might impact your practice or your personal liability. In Regional Transportation District v. University of Colorado Hospital Authority, a hospital doctor had treated a patient who had been in a bus accident and billed the RTD a couple of months later. RTD refused to pay the bill because it had not been sent to it within thirty days. The hospital argued to the Court that the 30-day notification provision of the law applies only to physicians and health care practitioners, not to hospitals.

Colorado law provides that

when an insured is an accident victim and a treating health care professional does not submit notice to an insurer within thirty days after the insured's initial visit, neither the insurer nor the injured person shall be responsible for the expense incurred for the medical procedure or treatment rendered prior to the late notification unless the late notification is the result of excusable neglect. The notice must include the name and address of the treating health professional, the evaluation or diagnosis, and the medical procedure performed or the medical treatment provided. The Court relied on a strict reading of the statute and

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

found that the hospital was not included within the statutory definition as it was not a health care professional.

Failure of a practitioner to meet these statutory obligations will result in the insurer and the patient being able to avoid payment of an otherwise reasonable and justifiable bill.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000

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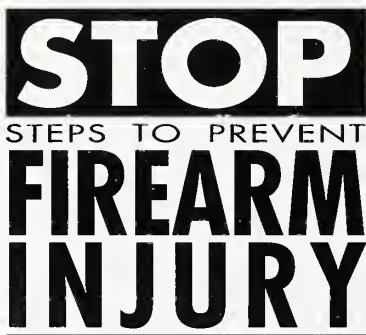
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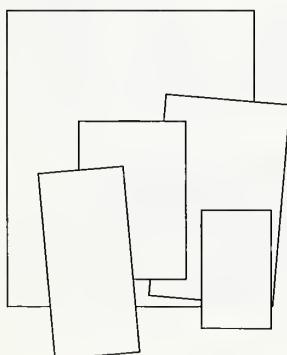


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EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



I am delighted to note that the Southeast Colorado Hospital District (SECH) in Springfield was named a finalist for the ***Foster G. McGraw Prize*** awarded by The Baxter Foundation for "Excellence In Community Service". As a finalist, SECH will receive a \$10,000 award.

Here is one more example of the quality of "rural" health care in Colorado. SECH District covers Baca County, the last county in southeastern Colorado. It also provides service to its neighboring counties. Springfield used to be described by some of the locals as "halfway between Lamar and Oklahoma", but it is in fact 49 miles from Lamar, which is the nearest acute care facility, and 275 miles from Denver's hospitals. Baca County is a population averaging 1.8 per square mile which, according to the Baxter announcement, "is considered a frontier area."

SECH is a public hospital facility with 25 acute-care beds, and is the only hospital in the county. As the story goes, in 1991, SECH was struggling to cope with the many challenges facing rural hospitals, and many believed the hospital would close before the end of the year. Instead, the hospital employees and the community received the support of the hospital board and came up with a plan: they just got together and determined the area's most pressing needs. Out of this came the award-winning "continuum of care" plan, including an Alzheimer's unit and an assisted living center. The assisted living center was established at an existing long-term care center in Walsh, Colorado, 20 miles east.

The Alzheimer's unit was established at SECH. In addition are the hospital's emergency medical services, covering a 2,556 square mile area, including 24-hour ambulance service.

Through cooperation with Denver urban hospitals, physicians covering a broad range of specialty practices are brought in periodically to staff the physicians' clinic and a satellite clinic in Walsh. These physicians come to SECH by private plane. Every other month, a portable mammography unit comes to the clinic from out of state.

Another interesting aspect of SECH is that it is located in the county with the highest rate in the state of cardiac disease. As a result, the new "continuum of care" includes a cardiac rehabilitation program.

Highlighting the effort is the hospital's "Grow Your Own" scholarship program, which is designed to encourage local people to complete their health care education and return to the hospital. This has already paid dividends: recently, five registered nurses and a physician's assistant have returned to the hospital after using the scholarship program to complete their training.

Well, I've only touched on the highlights of this outstanding rural health care program, but I am extremely proud of the physicians in rural Colorado who have made this their lives and who have contributed to such programs as the Southeast Colorado Hospital District.

As Annie Dukes, chief executive officer at SECH, said, "Five years

... coming together and beating back their adversary. . ."

ago, as a small rural hospital, our prospects for survival were clouded. But we've found that with confident, caring employees who give 110%, as well as an excellent board of directors and committed citizens, anything is possible."

I speak with confidence when I say all the members of the Colorado Medical Society salute the Southeast Colorado Hospital District for what they have done. And what they have done is much more than find a little public recognition by winning an award; it's the mustering of energies and resources to best meet the health care needs of a large and widespread community; it is showing the vitality of a people who are today described as living in a "frontier area" coming together and beating back their adversary, isolation. Not only that, the efforts have made SECH into a financially stable, locally controlled, confident organization of care-givers. As Arthur Staubitz, President of the Baxter Foundation, said, SECH "has demonstrated what those of us from the Great Plains call 'true grit'".

I like that, and I like SECH for what they've done

P

physician Practice Profiling



Leigh Truitt, MD

“... data are like caught fish”

The Physician Practice Profiling Committee of the Colorado Medical Society has spent the last eight months studying how managed care organizations profile the physicians participating in their panels. This has been an enlightening but somewhat frustrating experience. The science definitely lags behind the intentions and needs of both physicians and health plans.

The first observation that we have made is that profiling can take place at three different levels: the health plan, the local network and the group practice. Where it actually occurs is dependent on the organizational dynamics of the plan and the resources available at each level. If the plan relies on direct contracting with all its physicians or on a single independent practice association to provide care, then the profiling may well be only at the plan or IPA level.

However, there has been a

recent trend toward network health maintenance organizations in which care is provided through a network of multiple IPAs, physician/hospital organizations, group practices and other delivery mechanisms. In this case, profiling could occur through these entities if they possess the resources to do credentialing, quality assurance and utilization review without relying on the systems of the managed care organizations. Our observations suggest that this is seldom the case at present. With the growth of larger group practices on the order of 80 to 100 physicians, we may begin to see more sophisticated profiling at the group level.

The second observation is that there is confusion concerning what profiling really means. There are at least four different types of profiling possible as follows:

1. Economic profiling using administrative data from claims systems measuring such activities as per member per month costs, hospitalization rates, specialty referral rates, procedure rates, lab and imaging utilization rates, emergency room referral rates, etc.

2. Outpatient profiling covering inspection of the office site and medical records.

3. Population profiling listing immunization, mammography, pap smear, cholesterol testing, and other screening proportions for all the patients in a practice.

4. Drug utilization profiling measuring number of prescriptions per patient average cost per prescription, frequency of prescribing of different types of drugs, and others.

The third observation is that

there is an almost total lack of coupling of the results of profiling to desirable outcomes of care. For example, does a low rate of specialty referral result in better or worse outcomes for the covered patients? Does an office with adequate patient parking and well marked emergency exits produce better care? Do lower numbers of prescriptions or less costly prescribing habits result in lower or higher costs elsewhere in the system? We simply don't have these answers.

The fourth observation is that, although most commercial systems for physician profiling attempt to correct for age/gender, severity of illness and co-morbidity, there is still a significant residual difference in costs of care that cannot be explained by the numbers. Our committee firmly believes that the results of administrative claims based data profiling should be used only as a guide to further evaluation of the actual claim lines and not as a sole determinant of further participation in a provider panel.

The last observation is that most systems based on fully adjudicated claims produce accurate and relatively complete data that suffers because of lack of timeliness. Since these profiling systems are being used for the most part by managed care organizations to monitor physicians, a high degree of accuracy and completeness are essential if the results are not to be challenged by the providers. Because of the claims lag, the best systems are hard pressed to produce reports within six months of the actual dates of service.

Physician Practice Profiling

(Continued)

The discipline of accounting has recognized that for external reporting of financial performance to the shareholders and the Internal Revenue Service exact numbers are required — financial accounting standards. However, for internal management of the organizations, the requirements are much less rigorous but far more timely — managerial accounting standards. These looser standards work only as tools for the managers themselves; they work only because the managers understand what data are missing and what significance those data have.

If a group is willing to forego the comprehensiveness and accuracy that comes of full adjudication of claims plus tying in of hospital claims, a profiling system can be built off a billing system. What is lost in completeness and precision will be minor next to what is gained in timeliness. As many have remarked, data are like caught fish; they seldom improve with age. Such profiling is only acceptable and feasible if the providers are using it to manage themselves because only they know what is lacking and how to interpret the resulting reports.

The benefits of larger groups are that better information systems and larger numbers will permit the development of internal standards for specialty specific comparisons. Those of us who have relied on managed care organizations to provide information or management of groups and networks understand how important it is that we manage ourselves.

The Physician Profiling Committee continues to meet to study commercial physician profiling systems. We will soon make a decision how to convey the information we have gathered to our membership - possibly a report, a seminar or some combination of these methods.



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To donate supplies or for more information on Project CURE please call: (303) 727-9414.

This month supplies are being gathered for a family practice clinic in Albania. Supplies that are especially needed include: blood pressure cuffs, ophthalmoscopes, otoscopes, sigmoidoscopes and microscopes.

Colorado	Physician	Network,	Inc.
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David C. Martz, M.D., President
Colorado Physician Network

"We're off and running!"

The first annual meeting of Colorado Physician Network (CPN) membership was held in Denver on Saturday, July 27. Despite the allure of a gorgeous outdoor weekend, attendance by physicians from the Front Range area was substantial.

The program opened with updates by the leadership on the status of CPN followed by a lively Q & A forum. Other business included formal affirmation of the elected Board of Directors. New members Matt Baker (Durango), Laura Benson (Denver-Metro), and Ian Levensen (Denver-Metro), joined incumbents Tom Allen, Jack Berry, Joel Karlin, Murl Laman, David Martz, Louise McDonald, and Bob Yakely.

At the Board meeting which followed, the Board was expanded from 10 to 12 members to allow greater balance of geographical representation with 2 new At Large members. Gregg Omura of Grand Junction and Jeremy Lazarus of Denver-Metro were appointed to these positions. Officer election will occur at the September meeting.

Marketing has begun in the Southern Front Range, the Eastern Plains, and the Northwest areas. A new Front Range office in Pueblo is open, staffed, and functioning. Physicians' offices are calling to sign up as recipients as well as providers.

We are off and running! "Let the games begin!"

I s there a doctor in charge?

by Laura Pulfer

Reprinted from *The Denver Post*, Wednesday, July 17, 1996

"Are you really prepared to become just another employee?"

Memorandum

To: physicians

From: a person who occasionally gets sick

Subject: health care

Please permit me to be blunt.

Isn't it about time you rescue medicine from the questionable mercies of business and politics? You were the smartest kids in the class.

So what happened? Why are you letting everybody else tell you how to do your job?

Most of us are acquainted with dullards who became journalists and lawyers and insurance executives. But I can't think of a single instance when I've heard somebody observe, "Geez, did you hear that Buzzy Binkley became a doctor? I always thought that he was a little slow."

You people who became doctors were the good students, the book-worms, the Merit Scholars, the brains, the Eagle Scouts, the hall monitors. You were the ones whose homework the rest of us copied. Because you had the answers.

You are the people who have an arrogance so magnificent that you can put your hands around a pulsing human heart. You are the people with the grit to triage a bloody battlefield, to decide who will live and who will die.

You are the voice that gives the bad news. You are the ones we trust with our babies.

Only for you would we have worn those drafty paper robes, sitting on your cold examining table.

Only for you would we have waited in a room full of sick people and old magazines.

So, what's the problem? Are you scared of a bunch of bean counters? You whipped their butts on the SATs. And now they're making medical decisions "in consultation" with you. Consultation? Why aren't you running this show?

Are you really prepared to become just another employee?

Why have you allowed insurance companies and managed care to demand that young couples leave the car running when they enter the maternity ward? I'm not saying all new moms need to hang around the hospital for three or four days. I'd just like for you to be the one to decide when they go home.

Now, in addition to shorter stays, hospitals are planning to use fewer nurses. Are you going to let hospitals cheap out on the people who care for us when you're not there?

Of course, hospitals are just buildings and traditionally have been run by administrators.

But you have always been in charge of patient care. You and the nurses.

What's going on here?

Hospitals are simply doing what they've been forced to do — compete, cut, downsize. Stay alive.

At least they have a plan. What's your plan? Have you sent your best and brightest out to do battle, attend the meetings, work on the committees?

Is it the money? Is it us? Are you tired of taking care of us? And our untidy illnesses?

Does it honk you off that Shaquille O'Neal might get \$97 million to dunk round balls, and you still owe money on your med school loans?

So, maybe business is not your cup of tea. Maybe you hate meetings. Maybe you don't want to become a personnel expert or crunch numbers.

Fine. That's OK. You can hire somebody to do that.

But when I get sick, I'd still like to know that there's a doctor in charge. Not some MBA, not a benefits manager at Procter and Gamble or Kroger.

I sure don't want Hillary Clinton or Newt Gingrich or Ted Kennedy to be taking my temperature.

You will notice that I have a lot of questions.

Do I have the answers? Of course not.

I was not smart enough to be a doctor.

Laura Pulfer is a columnist for the *Cincinnati Enquirer*. Her commentaries are heard on Station KCFR in Denver and other National Public Radio affiliates

To: Editor, Cincinnati Enquirer

Re. Laura Pulfer's column entitled
"Is there a Doctor in charge?"

Laura Pulfer's editorial is well written and provocative. Obviously, the salient features that she raises have been frustrating to her as well as to physicians over the last decade.

She questions where the doctors have been during the avalanche of changes that have occurred and are

occurring in the health care delivery system. It would be impossible to calculate person-hours and resources expended by the medical profession in attempts to cooperate with or

counter governmental regulatory agencies hopefully to influence for the better - or, at least, to minimize the harm regarding the impact on quality of health care. Unfortunately, all efforts on parts of physicians seem to be perceived as being self-serving. There seems to have been little impact made on current external forces when regulations which affect health care providers are made by those without medical backgrounds and changes in some of the large medical care operations are influenced more by the bottom line (net profit) than concern for patient welfare or quality of care.

Our hope rests in citizens such as Ms. Pulfer who recognize the problem for what they are and are willing to speak out. We welcome your support in trying to neutralize greed disguised as efficiency.

W. Gerald Rainer, MD
Past-President, Society of Thoracic
Surgeons

Editor's Note: I found that more than one Colorado physician had read the Pulfer column in the Denver Post, but both Drs. Steve Thorson and Gerald Rainer felt it was worth reprinting here. Their comments, too, are very worthy of printing. Dr. Thorson is former CMS Treasurer. Dr. Rainer is former CMS President.

Cincinnati

To: W. Gerald Rainer, MD

26 July, 1996

Dear Dr. Rainer:

*Thank you for your note and ... your response to my column.
Thanks, too, for hanging in there. We need you.*

Best, Laura Pulfer



W. G. Rainer, MD
Denver, CO

Editor:

Laura Pulfer's column (**"Is there a doctor in charge?"**) makes me wonder what more can be done to **"rescue medicine from the questionable mercies of business and politics"**.

Individual doctors, I am convinced, can not do the job. They have tried by the thousands to do as Ms. Pulfer says, to go forth to battle, attend meetings and work on committees. They have bargained and negotiated with hospitals and insurance companies; they have testified at countless legislative hearings, served on even greater numbers of committees and attended meetings by the dozens.

And still, the label of "self-serving" seems indelibly imprinted on every license to practice medicine.

It was one-hundred and twenty-five years ago that the Colorado Territorial physicians came together to form the Colorado Medical Society.

Since that fateful day in September, 1871, the organization has spent much of its resources on doing in the public arenas what the individual doctor could not do.

As a group, beneath the umbrella of "organized medicine", the physicians have accomplished many great things, advocating the majority of advancements in public health which has lengthened and improved the quality of life for every person in Colorado.



Steven Thorson, MD
Fort Collins, CO

During the past two decades, this organization has been sending physicians and staff to attend those meetings, work on those committees, work with our government, its regulatory agencies and administrators in efforts to maintain the highest quality of medicine while advocating our patient's best interest.

What, then, can we do? Frankly, I don't think we have a choice but to continue to support and participate in the Colorado Medical Society, keeping its engine running as smoothly as possible.

There are a few other accepted physician responsibilities. Among them are:

- We must continue to adhere to our ethical principals.
- We must look for every opportunity to reinforce our role as patient advocate.
- We must work to sustain the quality of medical treatment and the betterment of health care.
- We must remain good and caring citizens, continuing to be "self-serving", because that same "service to self" is **all of the above**. As a physician, that's the only way I'd have it.

Sincerely,

Steven Thorson, MD



Good-bye

by **W. Gerald Rainer, MD**
Denver, Colorado

"Colorado . . . lost one of its most illustrious citizens."



Henry Swan II, MD
1913-1996

On July 13, 1996, the City of Denver, the State of Colorado, and Colorado medical practice lost one of its most illustrious citizens, and the field of cardiac surgery said good-

bye to one of its most outstanding pioneers in the surgical treatment of cardiac disorders. Henry Swan II died on this date, and with his passing he left a legacy for which Colorado can be justly proud.

Dr. Swan entered Harvard Medical School in the class of 1939 which spawned six professors and chairmen of surgery and innumerable professors in other specialties. Doctor Swan was the valedictorian of this famous class.

Dr. Swan took a Surgical Residency at the Boston Childrens and the Peter Bent Brigham Hospitals. Thereafter, he joined the U. S. Army Medical Corps in World War II and became chief of one of the teams in the 5th Surgical Group in the European Theatre. He returned to Denver as a Major with a room full of souvenirs and a wealth of surgical experience.

Dr. Swan began his Colorado academic career as Assistant Professor of Surgery at the University of

Colorado in 1946. The Clinical Chairman of the Department of Surgery at that time was Dr. John Foster, who groomed Dr. Swan for the position of Chairman and was the first full-time Chairman of the Department of Surgery at the University of Colorado School of Medicine.

Subsequently, during Dr. Swan's tenure as Chairman, the turbulent times of the early days of open cardiac surgery were filled with excitement, growth, and innovation. Dr. Swan had remarkable interests, imagination, research productivity, clinical and technical abilities. The Surgical Department, which had been almost unknown prior to that time, became a renowned center and attracted visitors from almost all corners of the world.

Dr. Swan was one of the first to recognize the possibilities for using hypothermia to prolong operating time on the heart. This was before the era of the pump oxygenator and only someone with Dr. Swan's skills and boldness could have pioneered this technique. The bathtub used in his days of operating on the heart with hypothermia is now in the Smithsonian Museum. He was the first to perform open operations on the aortic and pulmonic valves and pioneered the repair of atrial septal defects. As a follow-up to his interest in hypothermia, he published a book on ***Thermoregulation and Bioenergetics***.

Along other lines, Dr. Swan had enormous interests. He was an avid sportsman and claimed to be able to outshoot, outcast, outhunt and outskirt any and all comers. As in almost all other areas of interest, his enthusi-

asm as an aircraft pilot was without boundary.

He is survived by his wife, Geri, a son, Henry III, and two daughters Edith Swan and Gretchen Bering. The Colorado Medical Community will sorely miss his vision, his teaching, and his ability to stimulate curiosity in all of his students and residents.

From the June 11, 1977 issue of Saturday Review magazine.

By ALBERT ROSENFELD

FORT COLLINS, Colo. — The bear is only the best known of the many animals that hibernate. During hibernation, the whole organism goes into a state of deep torpor that lowers the metabolic rate and hence lowers all body functions. The notion that we might learn how hibernators perform this feat and then transfer the knowledge to human beings has been pursued since the early 1960s by a heart surgeon named Henry Swan. Now, in the late 1970s, here he stands, his tall, Lincoln-esque figure slightly stooped as he counts up, in the freezer of his lab at Colorado State University, some 250 tiny brains, all taken from hibernating ground squirrels of the species *Citellus tridecemlineatus*. With these he hopes to provide clear-cut evidence of his long-sought hibernation hormone.

In the scenarios of science fiction, astronauts are frequently put into deep hibernation for long space voyages. But of what use would such a capacity be to women and men on earth, here and now? For one thing, it would be a handy talent to possess during certain types of surgery—Swan's original motivation for seeking it.

An Open Letter to Colorado Physicians

concerning the future of the practice of medicine!

or the past two years Colorado Medical Society has been attempting to raise the awareness of physicians to the changes in medical practice brought about by computerization. Aspects of such change occur in patient records, administrative tasks including coding, billing, managed care and insurance claim filing, inter-office communications, Internet, electronic mail, etc., etc.

A short time back CMS developed more than one initiative to alert the physicians to making proper use of the computer as well as being aware how the computer could be used to the physician's detriment by lay persons, regulators at the federal, state and local levels, and managed care personnel entering medical computer data bases to the **disadvantage of both physician and patient.**

All of the above-mentioned aspects remain in the electronic and computerized medical field; however, each becomes more pertinent by the day and, as many have said, the future of medicine at the mercy of computers is NOW!" For all this, it seems vital to the physician that he/she be aware of the newly-emerging threats of non-medical and non-scientific incursions into medical practice. For this reason, it seems that there can be no more important physician education field than "computers in patient care", exchange of and protection of information, computerized medical records and non-physician use of computers in medical delivery fields.

I am just one of the CMS physicians who has specialized in these areas. This year, the Annual Meeting educational program has brought together a panel of experts in the field of medical computerization at a time we believe might be crucial. The physician needs to find out how his/her practice is likely to be influenced by the "mad onslaught" of new computer hardware, software, communications networks and data mining procedures.

M. Ray Painter, MD, President-elect of CMS, another expert in the field of computerized medical administration, sees this as one of the most important educational programs yet to be presented. We urge you to attend this educational program on Saturday, September 21, 1996, at the CMS Annual Meeting at Sheraton Steamboat Resort, Steamboat Springs, Colorado.

L. B. Golter, MD

Annual Meeting Educational Program Committee



Colorado Medical Society Annual Meeting Educational Program

Saturday, September 21, 1996
Steamboat Sheraton - Steamboat Springs, CO

Computer Science 341: A Graduate Course for Doctors

8:00 a.m. - 8:15 a.m.

Welcome and Overview - **M. Ray Painter, MD, CMS**

Presentations:

8:15 a.m. - 8:40 a.m.

Current State of the Art in Office Automation - **Jim Gabler**

8:40 a.m. - 9:05 a.m.

Current Community Health Information Networks (CHINs) and How They Work - **Bill Pankey**

9:05 a.m. - 9:30 a.m.

What is All This Outcome Stuff? - **Terry Fotre, DO**

9:30 a.m. - 10:00 a.m.

What is Wrong With This Picture? - **Roger Loeb**

10:00 a.m. - 10:20 a.m.

Break

10:20 a.m. - 11:00 a.m.

The Future of Healthcare Informatics - **Jim Gabler, Bill Pankey, Terry Fotre, Roger Loeb**

11:00 a.m. - 11:50 a.m.

Panel Discussion and Q&A - **Lee Golter, MD, Moderator**

11:50 a.m. - 12:00 noon

Wrap up - **M. Ray Painter, MD**

Colorado Medical Society Annual Meeting Educational Program

Faculty

Roger Loeb

Roger Loeb is Chief Executive Officer of The MarTech Group, an information technology consulting and software development business. He was formerly the CEO of a series of high technology startup companies and a senior executive with the A. C. Nielsen Company. He was the original architect of the physician communication network marketed by Integrated Medical Systems. He is the principal architect for the Pacific Bell Health Information Network (PCHIN), a state-wide Intranet being developed for the Health Data Interchange Corporation (HDIC) in California.

Mr. Loeb received a mathematics degree from the University of Wisconsin. He has appeared on the CBS Morning News a number of times to discuss information networks.

Bill Pankey

Bill Pankey is an alumnus of Stanford and the University of California. He has been a university professor, a principal in a company that developed mathematical tools and computer software used for creating multivariable statistical models, an independent consultant and software developer. For the past eighteen months, he has been involved, as a consultant to Pacific Bell and HDIC, in the creation of a state-wide California Health Information Network.

James M. Gabler

James Gabler is Enterprise Information Architect for HUBlink, Inc., a software development firm specializing in enterprise information integration. He provides senior guidance and direction in the areas of enterprise strategic planning, architecture design and product development.

As the Chief Information Officer (CIO) for two different multi-hospital systems, Mr. Gabler defined and implemented an integrated hospital information architecture using independent departmental systems as modules. The information architecture also prepared for extensive external links in anticipation of community/regional health care information networks well before the concept began receiving attention. During this period, Mr. Gabler was instrumental in helping establish and propagate the Health Level 7 (HL7) standards.

Before joining HUBlink, Mr. Gabler worked for a defense contractor and headed his own independent consulting practice, focusing on systems integration, regional health care information networks and business process re-engineering. He also worked with vendors to develop strategies for entering new markets and more clearly differentiating their products.

He is an expert in system integration design and information architecture and is an international speaker and widely published author. Mr. Gabler received his MS in Computer Science from Texas A&M and his BS in Mathematics from Harding College.

Lee Golter, MD

Lee Golter, MD has a degree in Electrical Engineering. He is an anesthesiologist who received his medical degree from the University of Cincinnati. Dr. Golter is also the principle architect of the Western Rockies Regional Health Information Network (WRRHIN) based out of Grand Junction, Colorado. WRRHIN is a regional electronic network connecting more than 300 providers, institutions and consumers of health care services with both dial-up and dedicated E-Mail services with access to reference and educational material. Since 1994 the network has provided a means for bi-directional transmission of health care information, provision of access to professional help and reference material for the general public, and methods of accessing distributed databases of medical record information in a secure environment.

The ABCs of Telemedicine: Accessibility, believability and cost

by Chet P. Seward
CMS Communications

“Despite the rural promise of telemedicine, the ‘seems so simple’ logic has proved to be ... difficult.”

The logic of telemedicine to many folks in rural areas is as straightforward as the ABCs. They don't have to worry about driving for hours to get to the nearest large hospital. Moreover, they don't have to worry about not getting quality, specialized care when an emergency occurs. Telemedicine to them is the missing link to big city medical care without all of the hassles associated with the big city.

Despite the rural promise of telemedicine, the “seems so simple” logic has proved to be more difficult to implement than any of Mrs. Johnson's first grade grammar classes. The list of frustrating reasons include: **access** to proper telecommunications networks is difficult; **believing** that the technology provides adequate privacy and patient confidentiality is debatable; and the **cost** of using such services can vary widely because of multiple carriers, government regulation and fragmented demand.

Integrated planning and coordination may be the biggest buzz words associated with access to

telemedicine because of the lack thereof by federal, state and private agencies. Huge steps have been and continue to be made to increase the infrastructure that is needed for telemedicine to be successful. Few believe that telemedicine can independently be cost effective. However, given society's recent penchant for cyberspace communication, telemedicine can become part of a larger policy to augment both public and private investment into telecommunications networks if steps are taken now.

Making the case for telemedicine's ability to safely provide quality data, while maintaining patient confidentiality, must also become a policy priority. Despite the fact that the security debate between the paper versus electronic medical record continues, believing in the viability of any telemedicine project must be based on the conviction that the physician-patient relationship is still sacrosanct. Determined computer hackers or careless/unscrupulous office workers can foil the best attempts at security for either electronic or paper records. Misuse or unauthorized use of medical data has been a risk that providers have faced for years. Every attempt should be made to maintain integrity. Daunting questions, like who owns the data and how can sensitive conditions (e.g. HIV infection) be prevented from indirectly being accessed by unrelated inquiries, remain. However, things like statements of understanding for videoconsultations and the Uniform Healthcare Information Act are steps in the right direction.

The final C for cost in the ABCs of telemedicine hinges on the structure of many networks. Local Access Transport Areas (LATAs) are the geographic boundaries of a telecommunications corporation's area of service. The scope of any telemedicine network can cross any number of these LATAs causing access confusion and incredibly high transmission costs. Many of these large corporations have a monopolistic stranglehold on rural areas of service. Government regulation of these corporations succeeds in muddying the waters even further, while limited demand in certain areas seem to legitimize high prices. There are those that argue that lifting regulations on those corporations will lower costs and increase demand. However, others are quick to point out that such monopoly power could prevent proper delivery of health care. Other questions related to LATAs and cost include, how can disparate networks and users negotiate fair rates when they lack the market power to do so, and if freely competitive markets are established should the government step in to prevent turf issues between in-state physicians and out of state mass pricing telemedical providers in order to maintain equity?

All of these issues, be they needs for better planning and coordination of telecommunications infrastructure, more technological sophistication to uphold patient confidentiality, or cost effective solutions to inter-LATA issues, must be addressed. The ABC logic is sound. Continued determination is the lesson plan to make it work.



John Lightburn, MD
Historian
Colorado Medical Society

Charities in early Colorado

Although the Catholic Church under the leadership of Bishop Joseph Machebeuf established the first and eventually the largest number of hospitals in the state, other religious and charitable organizations also made significant contributions to health care facilities of early Colorado. What follows is a description of the contributions of the Episcopal and Presbyterian churches, various labor organizations and other charitable organizations. In later issues, we will pay tribute to other churches and agencies in a series of articles on tuberculosis.

Our story begins in 1874 with the arrival of John Franklin Spalding from Erie, Pennsylvania, with his wife and four children to assume the post of Episcopal Bishop of Colorado. He was pleased with the Bishop's home and the two schools built by his predecessor, Bishop Randall, but he was troubled that there was no "church" hospital. There was St. Joseph's Hospital, but that was Roman Catholic and not satisfactory for good Episcopalian. Nor would the county hospital do for his parishioners who were the elite of Denver. And he may have felt that the little Frenchman, Joe Machebeuf, the Catholic Bishop should not have the only show in town.

Additional stimulus for building a "church" hospital also came from two women. Mrs. Tuton, an elderly parishioner of St. John's died, leaving two city lots to the church for the building of a hospital to be managed by the Episcopal church with the stipulation that the hospital

be "founded within two years of her death". The second woman was Mrs. Spalding who found the absence of "church" hospital intolerable. She became president of the Ladies' Aid Society which enthusiastically undertook fund raising projects to make the new St. Luke's hospital a reality.

With funds raised by the sale of Mrs. Tuton's lots and by the Ladies, the old Grandview Hotel on Federal Boulevard in North Denver was purchased for \$7,000. The hotel had been recently converted into a private insane asylum, a failed project, and was easily converted into a hospital. The building was a two story frame building with wide porches situated on five acres next to a small lake for boating. There were twenty-one rooms and three wards. The Rev. George Cornell was named the first Superintendent and the first patient was admitted on June 27, 1881.

The hospital opened with great expectations. The opening announcement described the fine view and indicated that the charges would be \$7.00 a week with more satisfying accommodations for those who were used to the best at a higher price. Soon after accepting his position, Superintendent Cornell sent a request to the board for a telephone, an ice house and a car. The minutes of the Board of Managers describe many problems during the first three years. The census was seldom high enough to pay for the expenses. They still needed a cow and a telephone. The water system failed when the well went dry. To make matters worse, the Board of

"The charities that soothe, and heal, and bless lie scattered at the feet of men like flowers."

Wordsworth

Managers dismissed the medical staff and passed a resolution that "hereafter the medical management of the hospital be intrusted to the medical gentlemen who are members of the Episcopal church in Denver after they shall be appointed by the Board of Managers". At this point, superintendent Cornell resigned.

Not surprisingly, there was much dissension among the physicians, and many meetings of the Board were devoted to reorganization of the staff. Finally, the Ladies' Aid Society intervened with a staff list which the board finally accepted. 1884 was the low point in the hospital's fortunes. The census slowly increased, and by 1887 the hospital was overcrowded, the result of a typhoid epidemic.

Nevertheless, it had become clear that the hospital was in the wrong place, and lots were purchased at 19th Avenue and Pearl Street, near Denver's prestigious Capitol Hill. Former State Supreme Court Justice Moses Hallett led the fund drive, and the new hospital was opened in 1891.

(Continued)

ARCHIVES (Continued)

Frederick J. Bancroft, M.D., played an important role in the early history of St. Luke's. He was a very large man, 6'4" and over 300 pounds with an imposing black beard and an infectious sense of humor. He was a close friend of Bishop Spalding, a mover on the Board of Managers, President of the Medical Staff, president of the School Board, president of the State Historical Society and president of the Denver Medical Society and the Colorado Medical Society. He was on the faculty of the medical school at the University of Denver and was instrumental in bringing to the hospital the first resident physician, Dr. C. R. Rivers to the hospital. Students from the University of Denver also received their clinical education at the hospital, and many younger physicians got their start with the help of Fred Bancroft.

Bancroft attracted other outstanding physicians to St. Luke's staff. Henry K. Steele, MD (city health commissioner and pioneer in control of infectious diseases), Arnold Stedman, MD (long time school board officer and member), Charles Denison, MD (authored a book on climate and lung disease), Edmund J. A. Rogers, MD (Surgeon and staff president who later studied and wrote extensively on the influence of the mind on physical disease), and Henry Sewall, MD (early researcher in immunity and vaccines). All of these men were truly giants in their fields who left a lasting heritage to the hospital, their profession and the community.

From these early beginnings, St. Luke's Hospital grew into one of the largest hospitals in the state eventually joining with Presbyterian Hospital to become the institution now known as *Columbia/Presbyterian/St. Luke's Medical Center*. Presbyterian Hospital came into being through the work of another charismatic surgeon who was also on the staff of St. Luke's Hospital, I. B. Perkins, M.D., 26th president of the CMS.

Recognizing the growing city's need for a new hospital, he approached the Synod of the Presbyterian church with his dream of a hospital. The synod agreed and Perkins provided the leadership that led to the completion of the hospital in 1924. So Presbyterian, born in the doctors lounge of St. Luke's, joined with St. Luke's 70 years later.

Less well known are two other St. Luke's Hospitals in the state that were started by the Episcopal church. After Bishop Machebeuf abandoned the idea of a hospital in Central City, the Episcopalians opened St. Luke's Hospital in 1870 for the care of the "afflicted without regard to creed, color, nationality, age, sex or "former life." Dr. E. Garrott was the physician-in-charge. He was aided by a Ladies' committee who visited and comforted the patients. Although the weekly charge was only \$6.00, those who could not pay were admitted anyway. With such a policy, the hospital closed one year later. Short lived but possibly the first hospital to have operated in Colorado.

In 1885, the Episcopalians opened a St. Luke's Hospital in Leadville. Little is known about this hospital. Incredibly, at one time Leadville had five hospitals: St. Vincent's Hospital, the Union Veterans Hospital, the Women's Christian Temperance Union Hospital, a county hospital and St. Luke's.

In addition to churches, citizens groups, miners' unions and relief societies built hospitals in the isolated mining towns such as Telluride, Silverton, Breckenridge and Georgetown.

There was enthusiastic support of the fund drive for building the hospitals but much less enthusiasm for supporting the operating costs. Then when silver was devalued, many of the mining towns fell on hard times and hospitals closed for lack of support and patients. On the other hand, those communities with more stable economies seemed able to build and maintain their hospitals. Some were built by city or county governments with tax money; some

were built by community organizations with contributions from community fund drives. Few, if any, ever made a profit, and nobody would have thought of investing in a hospital as a money making scheme. Indeed, they came close to bankruptcy during the "Great Depression" only to be saved by the new idea called "Blue Cross" hospital insurance. You know the rest. After the war came the Hill-Burton Act through which the federal government invested enormous amounts of money in new hospital facilities. Then came Medicare and managed care, and hospitals began to be profitable. Billions are now being spent to acquire hospitals by for-profit hospital chains, and the highest paid executive in Colorado is the CEO of a managed care hospital organization. So what started out as a struggling object of charity became the prized possession of giant for-profit corporations. What would Joe Machebeuf or John Spalding think?

There were two other important contributors to the hospital system of the state which we will describe in later issues: the many tuberculosis sanitaria established religious and charitable organizations and the hospitals built by large industries.



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The Choice Is Theirs

A video for physicians on Advance Medical Directives making End-of-Life Decisions

Are physicians well-informed and knowledgeable about Advance Medical Directives? Patients think they are, but some surveys indicate that many physicians don't know or understand current laws. *The Choice Is Theirs* video is specifically designed to walk the physician and his/her staff through the laws and their many features.

In an effort to assist the medical community and the public with questions on Advance Medical Directives, a consortium was formed. The goal of this group is to help educate all involved about these personal issues. The consortium includes: the Colorado Springs Osteopathic Foundation, Memorial Hospital, the Penrose-St. Francis Healthcare System, the Colorado Hospice Organization and Gonzaga University Television.

The Choice Is Theirs, a video about advance medical directives in the State of Colorado, (Living Wills, Medical Durable Power of Attorney and CPR Directives - Cardiopulmonary Resuscitation Directive) features Colorado and national experts from the legal, medical and medical ethic communities who answer the following questions:

1. What are advance medical directives as described in Colorado law?
2. What do these documents do for the patient and for the doctor?
3. When should advance directives be discussed with patients and families?
4. Who should have advance directives?
5. Where can the appropriate documents be obtained?

The Choice Is Theirs will be extremely helpful to the doctor, medical office staff, healthcare professionals, nursing educators, attorneys, and others. The video is a companion to ***"The Choice Is Yours"***, a video produced for the general public, patients and their families. The two videos complement each other, one directed to physicians and the other to the public/patient/families.

To order your copy of ***The Choice Is Theirs***, fill out the following order blank. Allow up to four weeks for delivery.

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Colorado Springs, Colorado 80933

1996 Fall Clinics

Physicians from Colorado and several neighboring states will gather in Montrose to participate in the 25th Annual Montrose Fall Clinics on September 27 and 28, 1996. The Fall Clinics are sponsored by the Montrose Memorial Hospital and its medical staff. In recognition of their 25th anniversary, the "best of the best" speakers from the past 25 years have been invited to speak again at this year's Fall Clinics.

These guest speakers will present various medical topics during the meetings which will be held at the Montrose Pavilion, 1800 Pavilion Drive.

Registration will begin at 8:00 a.m. on Friday, September 27, with lectures throughout the day, and from 8:30 a.m. through 12:30 p.m. on Saturday, September 28.

Scheduled to speak at the clinic are:

- Walter G. Briney, M. D., Clinical Professor of Medicine, University of Colorado Health Sciences Center, Denver, Colorado
- Nancy J. V. Bohannon, M. D., Associate Clinical Professor, University of California, Private Practice of Endocrinology, San Francisco, California
- William DroegeMueller, M. D., Robert A. Ross Distinguished Professor of Obstetrics and Gynecology, University of North Carolina School of Medicine. Chapel Hill, North Carolina
- John R. T. Reeves, M. D., Professor of Dermatology, University of Vermont, Burlington, Vermont
- Thomas N. Thomas, M.D., Private Practice, Forensic Psychiatrist, Maricopa County Superior Court, Phoenix, Arizona
- Lawrence L. Weed, M. D., Professor of Medicine Emeritus, College of Medicine University of Vermont, Burlington, Vermont

Topics discussed at the Clinic will be:

"Osteoporosis: How to Evaluate, How to Diagnose; How to Treat";
"New Treatment Options in Rheumatology";
"New Treatment for Diabetes";
"Secondary Prevention of Coronary Artery Disease";
"Vaginitis";
"Physician Burnout";
"Cocktail Party Dermatology";
"Dermatology Treatment Pearls";
"Knowledge Coupling: New Premises and Tools for Medical Care and Education";
"Vincent VanGogh: Mind, Madness and Medicine".

Interesting case presentations will be discussed at the end of Saturday's program by the participants as well as the guest speakers.

In addition to the medical lectures, participants will have the opportunity to visit over 50 pharmaceutical displays by various drug companies. These provide the physicians the opportunity to discuss new products and techniques with the company representatives.

Eleven hours of Category I AMA credit will be given to those attending the Clinic.

The Annual Fall Clinics Awards Banquet and dance will also be held at the Pavilion on Friday evening. Music will be provided by Swingtime in the Rockies. The post conference retreat on Saturday will be held at the Dickinsons at Telluride Ski Ranches in Telluride, Colorado.

Persons who would like further information on the clinic may contact Kathy Holman at the hospital, 303-240-7397.



BOARD HIGHLIGHTS

Highlights of the Board of Directors Meeting—July 26, 1996

Copic:

K. Mason Howard, MD, presented an update on a no-fault study for dispute resolution. He asked the BOD to support legislation to be written next year to re-vamp the dispute resolution system. He also requested approval from the BOD to submit a resolution to the CMS 1996 Annual Meeting to seek legislation to increase the mandatory licensure fee contribution to Colorado Physician Health Program.

Colorado Physician Network:

David C. Martz, MD presented an update on the Colorado Physician Network (CPN). The Division of Insurance approved the CPN marketing plan on May 1, 1996. Dr. Martz announced that CPN's first annual meeting was being held on Saturday, July 27, 1996, at the Holiday Inn SE.

Council on Legislation:

Ms. Lorraine Koehn, Director of the CMS Division of Government Relations, explained the Parental Rights Initiative bill, and stated that the bill is very broad in scope. She requested that the BOD approve non-support of this bill.

Executive Committee:

The BOD ratified a motion submitted by the Executive Committee to purchase the "Coding and Reimbursement Source Books" from Physician Reimbursement Systems. We will purchase these books at 1/3 of their original cost, and then resell them to CMS members at a minimal profit .

Finance Committee:

The BOD approved the budget for the 1996-1997 fiscal year. Approval was also given to purchase ten new computers in the 1995-1996 fiscal year, and ten more in the 1996-1997 fiscal year.



Joint Commission and COLA announce cooperative agreement

The Joint Commission on Accreditation of Healthcare Organizations and the Commission on Office Laboratory Accreditation (COLA) have initiated a cooperative agreement designed to reduce duplicative onsite evaluations of laboratories in integrated organizations surveyed under the Joint Commission's Network Accreditation Program.

Effective immediately, the Joint Commission will recognize and accept the accreditation process, findings and decisions of COLA when surveying integrated delivery systems and health plans. The Joint Commission requires that a meaningful sample of actual care delivery sites in a network, including laboratories, be evaluated in order for the network to receive accreditation.

The Colorado Medical Society officially endorsed COLA in 1994 when the commission received "deeming authority" from the Health Care Financing Administration. COLA is the only private, peer-review accreditation program to be approved as an alternative to federal inspection and review.

J. Stephen Kroger, MD, chief executive officer of COLA, said that the cooperative agreement "will result in a reduction in operating costs, as well as a reduced demand on financial and staff resources for laboratories."

Enrollment in COLA is on a voluntary basis. For further information on COLA, call (410) 381-6581.

CMS physician to run for AAFP Board of Directors

David M. West, MD, of Grand Junction, is running for the American Academy of Family Physicians (AAFP) Board of Directors. Dr. West, family physician, CMS member since 1979 and former Colorado Academy of Family Physicians (CAFP) President, will attempt to break the 20 year draught of Colorado representation in AAFP leadership.

"I believe I have always stood up for family physicians," say Dr. West. On that merit he believes that he is the right man for the job. He has been a member of the CAFP Board since 1986 and has served on numerous other councils and committees. Dr. West is basing his platform on the need to preserve the doctor-patient relationship, provide universal access, reform medical education, create a new medical liability system and push for better outcomes data and practice based research.

Code of Cooperation holds 48th Annual Meeting

The Code of Cooperation Committee recently held its 48th Annual Meeting in Colorado Springs. A distinguished panel of health care providers, representatives of hospitals and the news media, and members of the Colorado Springs Police Department discussed issues related to the media in the hospital. The panel was moderated by Dr. Alan Rapp.

Of specific interest was the call for continued cooperation amongst committee members in safeguarding the health of patients and providers, while addressing the need for public information given the increasing level of community violence. Gang violence and its tendency to provoke reprisal violence has forced hospitals to become

more security conscious and has thereby frustrated some of the efforts of the news media. All attendees agreed that the Committee was an essential element in maintaining trust amongst participants.

In other business, Dr. Leigh Truitt was elected as next year's committee president and plans were made to revise the committee's Public Information Guidelines for physicians, hospitals and the news media.



Panelist (l to r) Steve Smith, KKTV, Lloyd Wright, Colo. Spgs. Gazette Telegraph, Dr. Alan Rapp, Moderator, Capt. Velez and Lt. Liebowitz of the Colo. Spgs. Police Dept. discuss the issues.



Colorado Medical Society to offer new member financial services

“Another “2000 and Beyond” facet of the new financial program . . .”

Working with an investment services group in Denver, the Colorado Medical Society is planning for a new member service, beginning January 1, 1997. This service will take the place of the "Physician's Financial Program" conducted by Chase Manhattan Investment Services that served the Colorado Medical Society for over three years. That contract has terminated and, after careful consideration of numerous investment services and financial counselors a replacement has been chosen.

Colorado Medical Society Board of Directors has approved the endorsement of the financial program offered by HWC Group/Merrill Lynch.

The HWC Group, headed by Mr. David P. Halsch, has put forth a promising educational program, starting with 1) a survey of CMS members to determine the financial information needs of the membership and 2) establish an advisory board of CMS members to help plan seminars and other educational programs to best serve the wishes of the entire membership.

The survey is not intended to elicit personal financial information, but to encourage expression of personal wishes regarding financial or investment advice. Neither is the survey intended to sell any services of the HWC Group or Merrill-Lynch.

The Board of Advisors (initially planned to include six CMS members) will help construct seminar

programs that will be the most beneficial to physicians at large. The reason for this is an attempt to develop programs which best serve the entire demographic spectrum of CMS membership. When you

read the article on the CMS ***“Membership Snapshot”*** (pp 302-303) in this issue, you will understand the need of a demographically based plan.

David Halsch, a Merrill-Lynch Senior Financial Consultant, says his group's intention is to approach this with the idea of offering six seminars per year around the state. The Advisory Board would help see that these programs are well balanced per the expressed interests of the membership. Halsch said that the initial thrust of these seminars would be to "educate the membership about the financial services provided by Merrill Lynch". He went on to say, "The seminars will be education oriented and will give an opportunity for all members to attend. Topics are subject to recommendations and review by the Advisory

Board." Halsch added that, as in the past, these seminars will also be open to experts from other areas of finance. Though the CMS Board of Directors agreed on endorsement of the program, this does not extend any exclusivity to the HWC Group/Merrill Lynch in presenting educational seminars to CMS members. It will, however, give Halsch and his group the opportunity to consider such "other" experts for inclusion into their own programs.

Among other exciting aspects of the new financial program is that it includes plans for ***“E-Mail Answers”*** which includes a "bulletin board" of often-asked financial questions and quick-response answers from the marketplace. Another "2000 and Beyond" facet of the new financial program is a possible web linkage of CMS members to current financial information through our own "home page".

To keep CMS membership up to speed on the programs and on the ever-changing financial world, HWC Group/Merrill Lynch will be providing frequent columns in ***Colorado Medicine***. These and other features are still being developed, but most are expected to be operating by January 1, 1997, when the program officially begins.

The previous program was well received and offered considerable to the membership; however, with the merger of Chase Manhattan and Chemical Bank, the program was discontinued by the financial firm when their offices were moved out of Colorado.



David P. Halsch
Vice President
HWC Group

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Snapshot

by Chet P. Seward
CMS Communication

As the 125th Anniversary of the Colorado Medical Society approaches, it is appropriate to examine the makeup of current membership. Since its inception in 1871, the society has endeavored to be the advocate for physicians and patients in Colorado. Membership in the society has been and continues to be diverse. Physicians in fields as specialized as nuclear medicine to those in general practice have found a unified voice for organized medicine at CMS. The following organization snapshot serves to review membership makeup as specified by gender. It also highlights the top five specialty practices of member physicians.

As of August 1996 the number

of members in good standing at CMS totalled 5,019. Figure 1 shows that the bulk of the society's membership is made up of physicians in their mid 30's to late 50's. The largest component (1,652) is comprised of male and female doctors between the age of 37 and 46. Physicians between the age of 47 and 56 round out the majority. Strong numbers between the age of 57 and 86 demonstrate that the duties of medicine continue long past what others would call "retirement age."

It is interesting to note that women (especially those between 27 and 46 years of age) have increased their representation in the society. Much like their male counterparts, female CMS physicians have their

highest numbers in the 37 to 46 age group with 383 members. It is encouraging to note that more young, female doctors are becoming active in organized medicine as witnessed by their healthy representation in the 27 to 36 age group. (Note the dramatic difference in the ratio of male to female members in the youngest age groups. Typically outnumbered by an average of 25 to one among doctors between the ages of 57 to 86, female physicians have become even more involved as the average 4.53 to one ratio suggests amongst doctors in the 27 to 56 age groups.)

The marked dropoff in numbers between the age of 37 to 46 and 27 to 36 (1,652 and 671 members

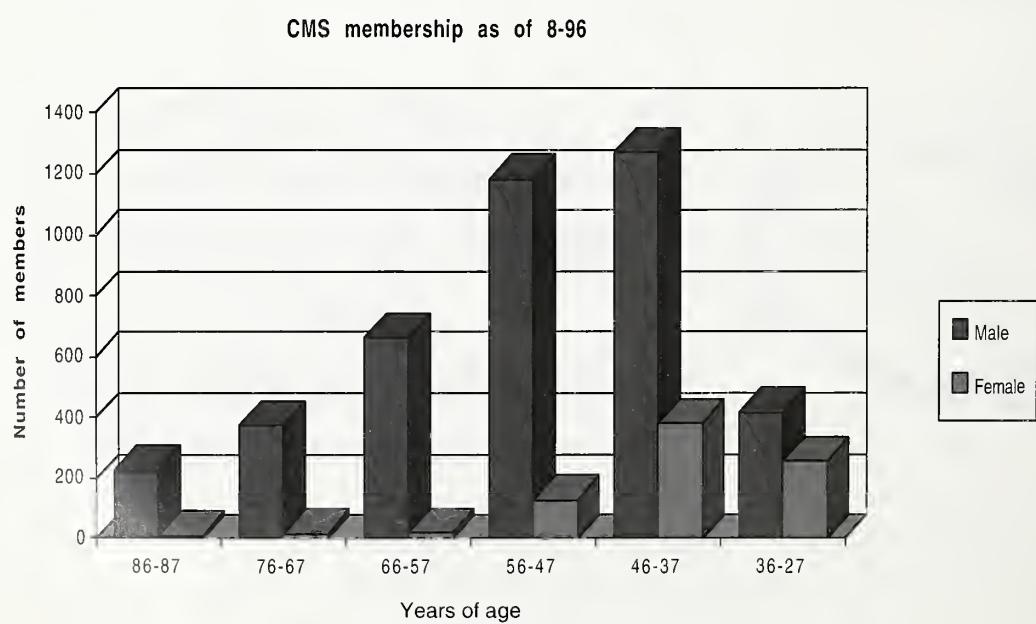


Figure 1

espectively) may represent the recent "specialization" of organized medicine. Many new specialty societies have effectively siphoned off many of the would be younger members to CMS. This number may also reflect a reaction to managed care as fee for service physicians have had to grapple with the significant changes in the fiscal aspects of medicine. Perhaps membership will increase once again as organized medicine demonstrates its effectiveness politically through its lobbying efforts and economically through its actions to improve quality by helping to implement physician-run managed care organizations and studying things like outcomes data.

An important characteristic of the CMS's ability to do such projects is the diversity of its membership. Similar to many other state societies, family practice (930) and internal medicine (656) make up the bulk of membership constituency. However, as figure 2 shows, specialty practitio-

Top five CMS member specialties

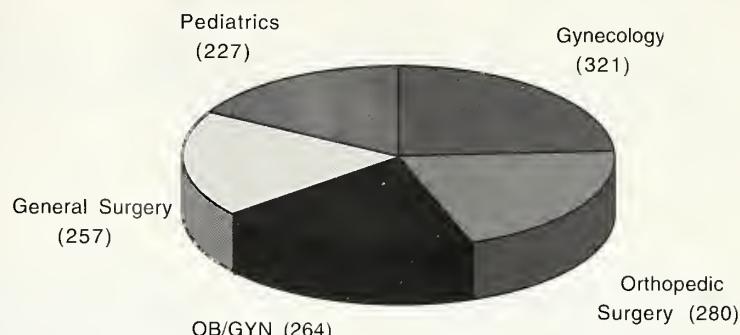


Figure 2

ners are an essential part of the society.

While gynecology, orthopedic surgery, OB/GYN, general surgery and pediatrics respectively represent the top five specialties, other specialties (anesthesiology, cardiology, emergency medicine, ophthalmol-

ogy and a host of others) are also well represented.

Hopefully this diverse membership will continue to aid in unifying the voice of medicine in Colorado in the year 2000 and beyond.

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OB-GYN OFFICE FOR SALE. Fully equipped, nicely decorated 1100 sq. feet. Good primary or secondary office near Swedish Hospital. Contact Jon W. Farinholt, MD 783-9339. 06/0796

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- 1500 sq. ft. partitioned for doctors office at \$1475 per month.
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Call Jack Horton, pager 509-3380, Bob Lowry or Heinie Foss, 279-3373, for appointments. 02/0896

◆ SITUATIONS WANTED

BOARD CERTIFIED orthopedic surgeon looking to relocate practice to Colorado. 8 yrs. experience. Willing to share space, buy practice or association. Please contact Steve Nadler, MD (305) 661-8081 06/0496

◆ PRACTICES FOR SALE

DENVER DERMATOLOGY PRACTICE FOR SALE: Doctor to relocate out of state, will stay with buyer during transition. Contact Hadley & Associates, Inc. (800) 684-0450; Fax (303) 688-0175. 03/0896

RETIRING ESTABLISHED allergy practice for sale. Successful oral immunotherapy method used for over 25 years. No hospital or HMO affiliations required. Interested physicians call Shelly. Monday, Tuesday, Thursday and Friday 8 am to 11 am. (303) 756-2621. 03/0796

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CONSIDER PATENTING YOUR NEW MEDICAL PROCEDURES, DEVICES & IMPROVEMENTS

For more information call Brian D. Smith P.C. Mr. Smith specializes in the Medical Arts. (303) 832-3666. 12/0296

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23 yr top producer 3% or 4.8% max. Written guarantee and references. There is a difference! Call and see how to save thousands but still get more and better service. Call Dick 745-7383. 12/1295

LOCAL LOCUMS is a Denver-based medical practice dedicated to providing quality locums coverage to Colorado family doctors. If you need to be away from your office or want to expand your practice without the risk and expense of hiring a new partner, we'd be happy to talk to you about how we can help. Please call Dr. Sheldon or Dr. Sowell for more information at (303) 370-6977. 11/0596

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RETIRING? MERGING? RELOCATING? PROJECT CURE WILL PICK UP YOUR SURPLUS MEDICAL EQUIPMENT, SUPPLIES AND BOOKS TO RECYCLE TO THIRD WORLD COUNTRIES. CALL JIM JACKSON AT 727-9414 OR FAX 674-9790. 12/1195



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BACK IN HEALTH - Multidisciplinary clinic seeks doctor to share space, and employee in DTC. Orchard and Holly. Beautiful office. Nice people. Please call (303) 770-4424. 06/0896



RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

"Fine, just shut up!"



Why do people like history? For one thing, it's a lot easier to keep up with history than it is to keep up with progress.

As for me, there are some things about the past I just like BETTER than I do the present. For instance, one of my departed friends, Ranger Rogers whom I really enjoyed, is a joy to look back on, principally because he was such a great character. There aren't many characters like Ranger coming along these days. Ranger was the son of James Grafton Rogers, whose CV read like an International Who's Who.

Ranger himself was no slouch: a distinguished attorney, Colorado State Senator (1953-1964) and a true-blood Colorado native. His sister, Lorna, was the late Mrs. Stephen H. Hart. It was, in fact, James Grafton Rogers and his son-in-law, Stephen Hart, who created the Colorado State Historical Society.

Ranger told me of his family's origins and their coming to Colorado. They were an "up-East" family of blue-bloods who came west (at least as far as St. Louis). There were four brothers, each distinguishing himself in his own way. One of the four, Ranger's grandfather, became an officer in the United States Army (post-Civil War) and traveled further west to fight Indians. Ranger says his grandfather was a tall, handsome Cavalry officer with an almost-Scandinavian look about him and he had a head of wonderful blond hair. In Colorado, the Indians hated him (with good cause) but they admired him as well. In particular, they wanted his scalp because they had not seen anything like that golden hair, and certainly had never obtained a blond scalp.

Ranger's grandfather did not die at the hands of the Indians, but instead died of smallpox. When he was buried, the soldiers mourned and the Indians celebrated. They didn't rest there, however. When the dust settled the Indians disinterred Ranger's grandfather's body and scalped him, carrying off that beautiful golden mane and its extrinsic parts.

It wasn't long until the Indian frontier was overcome by a lassitude uncommon to the Indian. Soon, there were widespread deaths among the tribes. Army physicians determined that the debility and death was due to a smallpox epidemic, obviously caused by Ranger's grandfather's scalp. Well, you just don't know.

In another light altogether, I read a piece last week that reminded

me of my own past, years ago when I hosted a radio jazz program. Each week, when I introduced the program and myself, I always invited the listener to sit back, relax, listen to the jazz I had selected, accompanied by as little chatter as possible. I consistently ended this with the admonition: "If you don't like the program, don't bother calling or writing me; just tune your radio dial to another station." I could get away with that because I owned the radio station, and if I was going to be stuck with doing this thing, I was certainly going to do it **MY WAY!** Over time I received numerous comments about this attitude, but never any complaints (understanding that "numerous" need be only two or more, and no complaints might indicate that few or no persons were even listening). Well, you just don't know.

The piece I read was the column, "**Observant Curmudgeon**" in the *Rocky Mountain Health Care Observer*. It was titled, "Silence, Please."

The column begins "American airlines suffer from the delusion that the number of PA announcements made during flight is a measure of costumer service". The column ends saying the airline welcomes any suggestions to "make your flight more enjoyable". The Curmudgeon's suggestion: "Fine. Just shut up!"

Herein lies the basic reason for "**Ruminations**" always being the last piece in this magazine: you can take heart in seeing **exactly where** I'm going to "shut up".

Now that's progress, with a little history thrown in.



M. Ray Painter, MD
President, 1996-1997

Dr. Painter's inaugural address delivered on September 21, 1996, at the Colorado Medical Society Annual Meeting.

What is CMS?

CMS is a composite of all of us, an organization of physicians for physicians and our patients. It's an organization with a duel and stable mission: Patient advocacy first, and then we are physician advocates. We have had constant changing goals. The practice of medicine has changed and will continue to change even more dramatically in the future.

In keeping with the theme of this meeting, I will just mention the past, leave the present for the rest of the meeting and spend most of our time on the future.

I must share with you that I have seen the future of medicine, and it is bright! We are in the dawning of a new era.

In my lifetime I have seen many changes in medicine. In fact, I was born at home. The doc traveled about 20 miles in a buggy, and he didn't worry about malpractice. That was the norm in that rural area of Alabama at the time.

I attended high school in a rural area where there was one physician who did everything. Referrals were almost unheard of.

When I was in medical school we had the world by the tail. The future was bright and we could go anywhere we wanted to practice!

Yes, I have seen the golden era of medicine. I started practice during the times when I was the King. I could do what I thought best for my patients. No one questioned my advice. Quality was determined by me. I was in control!

I have also experienced one of the most frustrating eras that medicine will ever see. Patient's distrust, physician bashing by the federal government and society, loss of control, malpractice as a constant threat.

Insurance claims are rejected for minor, nitpicky reasons and if I don't document the patient services "properly", I'm guilty of "Fraud!". In fact, according to the criteria being used in judging medical schools, we are all guilty of fraud. And that's not the worst part. The worst part is that my patients come to see me, not because of my reputation or because of their desire, but because of my contractual affiliation.

Yes, we are currently living through the most difficult times for medicine that any of us have ever witnessed, and they are not over. But things will get better!

Well, what happened on the way to the health transition game? I'll tell you what happened. Patients and physicians were left out of the revolution - that has been the irony of the transition so far. Neither group was ready! Neither group knew how to play the big business game.

The Managed Care Revolution (not Reform) in which we have been forced to participate was started by the federal government, embraced by employers and has been fueled by business. Making a profit is a way of life in our capitalistic system. Entrepreneurs saw a golden opportunity. We were a major industry ripe for transition! Physicians were a commodity, to be bought, sold, and contracted with for the lowest price. Doom and gloom prevailed!

"O.K. we've got 'em right where we want 'em".

Many feel that we have lost. It's too late! It's hopeless! The insurance companies have taken over.

Remember "The Drive" in the game between the Bronco's and the Cleveland Browns. The ball was on the Bronco's 2 yard line. Less than five minutes to go and 4 points behind. Keith Bishop came to the huddle and announced "O.K. we've got 'em right where we want 'em".

During the first part of the revolution, patients loved the cost savings. Actually, physicians didn't mind either. It was the hospitals that were taking a hit.

Now, however, patients are concerned! Lack of choice, quality, control by non-physicians, etc.

Physicians have been hurt and are concerned.

Now both groups are ready to get involved. It's time to create the next generation in which there truly will be a partnering between physicians and patients.

We have not lost! The game is not over! We have an opportunity

(Continued on following page)

PRESIDENT'S LETTER (Continued)

equal to that Bronco drive, to regain control, to win! There is one caveat! We have to create the future.

I'm not off my rocker! Let me explain. Medicine has been transformed into a free market business. Jeff Goldsmith stated at the most recent Montgomery-Dorsey Symposium: "In the market place no one stays in control long". Physicians had control. Insurance/managed care companies now have control. Who is next? Health reform is not over!

We have the clout. We can do it! A patient's request and a doctor's suggestion spends 75 to 80 percent of the health care dollar. Is that clout? You bet it is. We can team up with our patients. We have a role to play. We must assume leadership in reshaping the future health care system to provide choice, availability, continued money for research, assure quality at every turn, and to preserve our profession and all it stands for.

We must accept that role.

(But are we ready to prepare ourselves to play the game? Are we willing to spend the time, pay the price, take the risk?)

The opportunity is there. I submit to you, patients will soon control the market place! And they need us! They need our help. The system needs us! They need all physicians.

Physicians should form alliances - gain bargaining power - share the risk. Physicians are forming physicians' groups such as CPN (Colorado Physician Network). We need to partner with insurance companies and patients. Look at CPN—RM-HMO (Colorado Physician Network/Rocky Mountain HMO). This is just one example of action. This is one way to fulfill our role. What next? How do we redefine our role with other insurers? With the government?

Medicine has been transformed into a free market business. Some people say that's bad, but from

where we stand right now, I say that's good. We have the opportunity to participate for a better future.

In order to accomplish anything one has to set common goals; formulate a plan of action. Yes, you have to know where you're going before you know how to get there. We have to learn the business of medicine. It is a business. We have to know the bottom line, and learn to apply what we know. We have to know what it costs to do business. We must know the true cost of practice, understand economic credentialing, payment rules, and all the rest of medical practice business. And we have to quit signing all those contracts that are not economically feasible. It's embarrassing to see some of the contracts that many of our colleagues have signed. How are we going to quit doing that? We're going to quit signing bad contracts based on improper information. We need to know the bottom line. The only way to accomplish that is through the use of good information.

There's a new Golden Rule in business: Those who have the data, have the gold.

So, fellow physicians, the real question in my mind about the future is: are we willing to spend the time, take the risk, pay the price, and play the game.

Colorado Medical Society — What roles do we play? Now this is where this talk got a little tough. We are the ones who have to decide which direction to take. This past year's survey and the Leadership Conference.... made several things clear: We do legislation real well; we do many other things real well. But what else? What else should we do? What actions can we take?

We need to unify the profession. CMS needs to be the umbrella and bring all of the profession together. Hopefully, at this meeting, we'll pass a resolution to bring all of the players together. We're going to start a collaborative committee to tackle all of those tough issues, the turf issues, the split-the-pie issues. We have to bring them into the house of medicine and to discuss them. We have to be in concert as we move

forward.

The second is information. We have to capture it, to organize it, to work with it. What else should CMS do with information? We need to locate it, to make it available to our membership, and we need to be sure it is quality data. We want to be sure that we're using the data FOR our physicians, and FOR our patients, rather than having it used AGAINST us.

And we need to mobilize the troops. We have the expertise; we just need to identify and organize it. We need to do a better job of networking. Someone told me recently that it's not what you deserve in the business world, it's what you negotiate! Half of accomplishment is networking. We have to take collective action. There are many things we can accomplish, if we act in concert.

In summary, CMS must define its new role, set goals such as concentrating on information, education and legislative support for our membership. Then we must act together! Unite the profession!

Anything is possible. If we define our role, set our goals, then act!

Let me ask you one question: CMS, are you willing to spend the time, pay the price? Are you ready to play the game ... the game of support for the physicians... to play the game in the new arena? It's easy to talk the talk... but can we walk the walk?

In closing, I'd like to share with you a quote; this is one my Dad told me many times and I've always found it to be true: He said "Son, be careful what you want. You might get it."

Thank you.

CMS Med Fax®

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax®
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

CMS opposes Parental Rights Amendment

The proposed Amendment 17, Concerning Parental Rights, has the potential to dramatically affect relationships between health care providers and their young patients. The Colorado Medical Society officially declared its opposition to this amendment during the 1996 Annual Meeting.

The proposed amendment declares that parents have the natural, essential and inalienable right to direct and control the upbringing, education, values, and discipline of their children. This broad language raises many questions about how it may be applied. Interpretation of the amendment could be a trial attorney's dream; passage of the amendment could result in a deluge of court challenges to state laws, like child car seat restraint legislation, which the CMS originally helped pass. Additionally, the amendment could: prevent children from receiving immunizations and preventative medical care; limit the rights of minors to access confidential medical services, as well as possible emergency medical care; place children at a higher risk of child abuse and physicians at extreme risk when reporting child abuse; and allow the defense of spiritual healing to prevent a child from receiving medical care when a condition is life threatening.

Under current state law the rights of parents and children are recognized.

Supporters of the amendment claim that it will curtail excessive government intrusions into family affairs and increase parental freedom in performing parenting roles.

Please contact the CMS Department of Government Relations (1-800-654-5653 or 779-5455, Ext. 2410 or 2427) for more information about the opposition of Amendment 17, Concerning Parental Rights. Staff will supply you with a flyer which you may copy and distribute to your patients explaining why Amendment 17 is unnecessary and dangerous. To assist in defeating this amendment please contact the Protect Our Children Coalition at P.O. Box 18265, Denver, CO 80203 or (303) 360-8911.

Election Day is November 5. Don't take the chance of being detained by the office or surgery on election day. Contact your County Election Commission or Clerk of Courts and request an absentee ballot. If you would like information on state legislative candidates, please contact CMS Department of Government Relations staff.

Colorado physicians to evaluate managed care health plans

In October physicians in Colorado will have the opportunity to voice their opinions about managed care health plans. The American Medical Association (AMA) and Hewitt Associates have developed the Physicians' Health Plan Assessment Survey. This survey covers everything from quality of care to plan management. Randomly selected primary care physicians and specialists practicing in certain zip code areas will receive a survey.

The CMS and the AMA believe that this information

is both essential and long overdue. While many sources are monitoring patient satisfaction with health plans, no one has specifically asked physicians their view of plan policies. This is your chance to provide critical feedback.

Results of the survey will be distributed by Hewitt and Associates to more than 300 "Fortune 500" companies that collectively cover over 18 million individuals.

(Continued on page three)

MONTGOMERY
LITTLE
&
McGREW

ATTORNEYS AT LAW

Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm
of Montgomery Little & McGrew, P.C.

This column contains information concerning topics
of general interest in the medical-legal field. For further
information or help with specific problems, please
contact Montgomery Little & McGrew, P.C.

Independent medical examinations: Physician accountability to patients

In April of 1996, Colorado added a new set of laws addressing the standards of practice for physicians performing independent medical examinations (IMEs). It also places constraints on insurers and other interested parties who might attempt to influence the outcome of an IME. The statutes fall within the Title of the Colorado Revised Statutes concerning Insurance issues. Section 10-16-601, *et. seq.*, Colorado Revised Statutes (1996).

The law is in part a codification of recent case law addressing the duties of physicians performing IMEs, to patients seen for this limited purpose. The substantive portion of the statute provides that all IMEs performed by a doctor must be performed in accordance with generally accepted professional standards of practice. Section 10-16-603.

It further provides that the performance of an IME not in accordance with generally accepted professional standards of practice will be considered "unprofessional conduct," the term used in the Medical Practice Act and elsewhere to determine whether action should be taken against a doctor's license.

The stated purpose of the legislation is "to ensure that patients have access to the best possible health care decisions and information, to increase the confidence of consumers that doctors will be truly independent medical examiners." Section 10-16-601. The legislation may have been motivated at least in part by concerns (1) that some physicians were crossing the boundary from independent medical professional into the realm of professional medical witness or advocate for one side or the other in insurance disputes, and (2) that some insurers, attorneys, patients, and others were becoming increasingly aggressive in attempting to influence the outcome of the IMEs for their own benefit.

These concerns are evidenced by the provision – which would seem obvious to the naive or inexperi-

enced – that no insurer, employer, employee, patient, or their agent or representative shall attempt to dictate to any doctor performing an IME, the type or duration of treatment or the results of the examination.

Additionally, no doctor performing an IME shall have a financial or economic interest in the type or duration of treatment or the results of the examination.

The statute applies to "Doctors," "Patients," and "Insurers." "Doctors," is a broad term encompassing "persons licensed as a doctor under Title 12 of the Colorado Revised Statutes, to provide health care to a patient." This includes but may not be limited to physicians, podiatrists, chiropractors, dentists and optometrists.

An "Insurer" is broadly defined as "a sickness and accident insurer, including a provider of personal injury protection (PIP) benefits, and any HMO, fraternal benefit society, nonprofit hospital, medical-surgical and health services corporation, prepaid health plans, or other entity providing health care coverage or health benefits or health care services, whether as a principal, indemnitor, surety, or contractor authorized by the commissioner to conduct business in Colorado. Although "Insurer" includes some self-insurers, it does not include insurers or self-insured employers under the Workers' Compensation Act.

Finally, "Patient" refers to the individual insured under any health coverage of health benefit or health care services certificate, agreement, contract, policy, or plan. It also includes a covered employee or dependent of an insured person.

The general principles of avoiding conflicts of interest, exercising independent professional judgment, and ethical if not legal obligations to all persons evaluated, are not new. However, their codification into a separate part under the insurance laws signals an increased scrutiny of both doctors and insurers, as well as attorneys and patients involved in the complex web of insurance claim matters and personal injury litigation in general.

CMS Med Fax

(Physician survey continued from page one)

These companies want to know what physicians think of specific health plans. Survey results will aid in the evaluation and purchase of health plans.

Specific zip code districts in Denver include those beginning with 800 through 805, and 808 through 809. Surveys were mailed October 4 and are due back at the AMA by November 1.

The AMA will use the survey results to identify areas of concern for physicians and to advocate that health plans address these concerns. Physician responses **will be kept absolutely confidential**.

If the response rate in Colorado is good, then the AMA will share aggregate results from markets in the state with the CMS. This information will assist CMS in pinpointing specific, physician concerns about managed care in Colorado. If you receive a survey, please take a minute to fill it out and return it to the AMA by November 1.

CMS and CMGMA sponsor candidate forum

The Colorado Medical Society (CMS) and the Colorado Medical Group Management Association (CMGMA) are sponsoring a forum of Colorado candidates seeking election to the U.S. Senate and U.S. House of Representatives. Entitled "Positioning for Healthcare '97: Meet Your Candidates", the program promises to be a lively look at health care issues which future legislators must address.

The forum will be held on October 25 in Englewood, Colorado. Continental breakfast will be served. To register please call the CMGMA at (303) 397-7888, or call the CMS Government Relations Staff at (303) 779-5455 or 1-800-654-5653.

Women's health care conference to be held in Denver

The Colorado Department of Public Health and Environment and the University of Colorado Health Sciences Center will hold an interactive conference on major risk factors and health conditions affecting women in Colorado on November 7 in Denver. Intervention strategies to improve the health status of women will be explored.

Dr. Linda Lewis Alexander, Vice President for Women's Health, Science Management and Program Development for United Information Systems in Bethesda, Maryland, will be the keynote speaker. Dr. Alexander will provide an overview of the health care issues affecting women and the status of women's health research.

Physicians, physician assistants, nurse practitioners, nurses, dietitians and health educators in clinics, public health agencies, hospitals, and women's centers are all invited to join in addressing women's health care issues in the 1990's.

Practical and clinical breakout sessions will address: systematic breast exams; the risks and benefits of hormone replacement therapy; strategies for developing osteoporosis prevention projects; ways to identify domestic violence; the effects of smoking, physical activity and good eating; and much more.

To register for this conference please call (303) 692-2580.

You're too busy practicing medicine to play politics.

Fortunately you have COMPAC. Support COMPAC today and rest assured that the voice of medicine is heard at the capitol.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

Denver Reg. Office of the FTC

FTC Health Care Antitrust Conference
October 25, 1996
Denver, Colorado
Contact: Pam Cole at (303) 844-2255

University of Colorado's CME in the Rockies

42nd Family Practice Review
October 28-November 1, 1996
UCHSC, Denver, Colorado
(303) 372-9050 or 1-800-882-9153

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
November 7-8, 1996
Englewood, Colorado
(303) 397-7876

HIV Clinical Training Program

Col. AIDS Educ. & Training Center and UCHSC
November 13-15, 1996
Denver, Colorado
(303) 355-1305

International Meniere's Disease Research Institute

8th Annual Seminar and Workshops: Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders
December 4-7, 1996
Denver, Colorado
Contact: Jane Wells, (303) 788-4235

Colorado Hospital Association

Accreditation Standards for Hospital-Based Ambulatory Care Services
December 5-6, 1996
Denver, Colorado
(303) 758-1630

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
December 5-6, 1996
Englewood, Colorado
(303) 397-7876

University of Colorado's CME in the Rockies

5th Update on Infectious Disease:
Bugs and Drugs in the 90's
December 6-7, 1996
Denver, Colorado
(303) 372-9050 or 1-800-8820-9153

American College of Cardiology

The 28th Annual Cardiovascular Conf. at Snowmass
January 13-17, 1997
Snowmass, Colorado
CME Credit: 22 Category 1 AMA
1-800-253-4636 ext. 695

Disease Management Congress

Implementation and Outcomes Measurement
January 14-17, 1996
San Francisco, California
800-446-6422

HIV Clinical Training Program

Col. AIDS Education and Training Cntr. and UCHSC
January 15-17, 1997
Denver, Colorado
(303) 355-1305

American Diabetes Association & Colorado Society of Endocrinology

33rd Annual Colorado Diabetes/Endocrinology Inst.
January 18-23, 1997
Aspen-Snowmass, Colorado
1-800-782-2873

American College of Cardiology

Cardiovascular Conference at Snowbird
February 12-14, 1997
Snowbird, UT
1-800-253-4636 ext. 695



Physician Profile Project

Please let us know what you think!

By now most of you have received a copy of your physician profile. We hope you have made copies available to your patients. Please answer the following questions to help us evaluate the success of the project.

1) Are you participating in the physician profile project? Yes _____ No _____

2) In which of the following ways do you make your profile available to your patients?

- copy on display for viewing only
- distributed in office
- mailed upon request

3) Have you attached your own addendum to your profile? Yes _____ No _____

If yes, what information have you included:

- You and Your Doctor* brochure
- additional office locations
- office hours
- additional professional training
- payment/billing information
- publications
- further explanations of information listed on profile
- other: _____

4) In general, have your patients found the information contained in your profile to be useful/informative?

very useful _____ useful _____ not useful _____

5) Has the availability of your profile enhanced the communication between you and your patients?

- definitely enhanced communication
- slightly enhanced communication
- no change

6) If you are not participating in the Physician Profile Project, please tell us why not.

- don't know about the project
- never received my profile
- currently awaiting revised profile
- do not think the profile is useful
- other: _____

We value your input. Please provide us with any additional **comments/suggestions:**

Name: _____ Phone: _____ Specialty: _____

This project is open to all Colorado Physicians. If you have not received your profile, please call Ellen Stein at 930-0414 or 1-800-654-5653. We are still working on revisions of some of the profiles that you have returned to us for correction. Revised profiles are generated on a monthly basis.

Thank you for completing this survey. Please return it via fax at (303) 771-8657 or mail the survey to:

Colorado Medical Society
P.O. Box 17550
Denver, CO 80217-0550
Attn: Ellen Stein

Volunteer Opportunities at the Hall of Life Exhibit!

The Hall of Life Health Education Center at the Denver Museum of Natural History is now accepting volunteer applications for their September 1996 exhibit training.

As a volunteer you will be part of a team to either provide visitor service, lead school tours, or interpret the exciting hands-on exhibits with the use of specimens and objects. Weekday, weekend and evening positions are available. Some postions available now.

If you are interested in becoming a vital part of health education, please call the Volunteer Office for more information.

Telephone (303) 370-6419

**The Denver Museum of
Natural History
2001 Colorado Boulevard**

LEGAL UPDATE

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

Medical malpractice damages: The parent's claim for negligent infliction of emotional distress

Unfortunately, during the process of providing medical services to pregnant women and to minors, injuries sometimes occur which, at times, reach levels described as "catastrophic," "serious," or "fatal." While none would deny that injury to, or loss of, a child or fetus is an emotionally devastating event to a parent, Colorado law is very restrictive concerning the circumstances under which a parent may successfully sue a wrongdoer for the tort of negligent infliction of emotional distress. Colorado law does not permit a parent to recover for negligent infliction of emotional harm as a result of viewing injury or death to the parents' child unless the parent was subjected to an unreasonable risk of bodily harm by virtue of the negligence of another. In

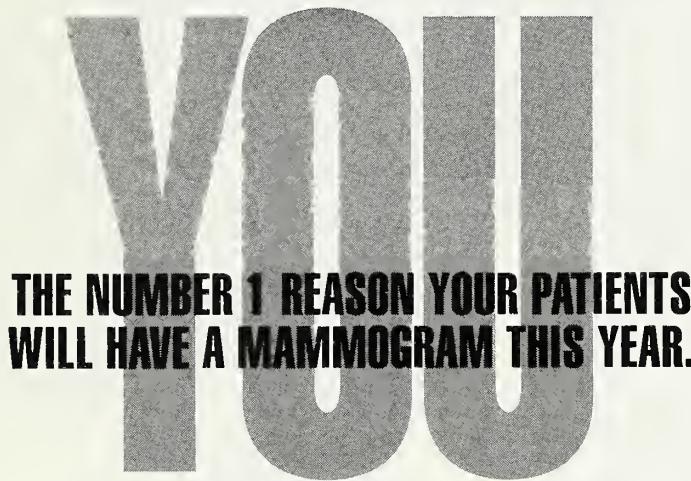
other words, the parent must have been within a "zone of danger" himself or herself to be able to recover from a physician for psychic trauma associated with emotional distress. In an obstetrics situation, is a mother exposed to an unreasonable risk of danger for risks attendant to pregnancy and child birth. While some believe there should be a remedy for every wrong, the courts have found that ideal limited by the realities of life. The problem for the law is to limit the legal consequences of wrongs to a controllable degree. It is the potential of unlimited liability that has motivated Colorado Appellate Courts to limit claims to those persons subjected to an unreasonable risk of harm because of a wrongdoer's negligence.

In summary, a claimant must prove by

a preponderance of the evidence that (1) the wrongdoer's negligence created an unreasonable risk of physical harm to the claimant, and (2) negligent infliction of emotional distress claim. Since the process of child birth or the treatment of a minor child for injuries sustained by one other than a physician are circumstances wherein it is highly unlikely that either of the two elements necessary to prevail can be proven, let alone both, the physician need not concern himself or herself related to this type of claim.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
(303) 861-1000



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Sandra L. Maloney
Executive Director
Colorado Medical Society



The Colorado Medical Society, at its Annual Meeting September 22nd, soundly passed this resolution. This issue, the so-called "Parental Rights Amendment", would forever amend the Constitution of the State of Colorado and seriously endanger the relationship of health care providers and their patients by eliminating state laws such as mandatory immunization or child car seat restraint laws. The passage of these laws were vigorously supported by the Colorado Medical Society in years past, and there is no reason to change now. Passage of Amendment 17 would overrule all the good that has been done by physicians and other health care providers in the past.

At the present, the medical practice profession is working hard on reducing domestic violence and child abuse through a variety of programs and efforts. Passage of this amendment would have unintended consequences. Lou Kelly, chair of "Protect Our Children Coalition" (a group of over 100 Colorado organizations opposed to the amendment), says Amendment 17 "will give child abusers an affirmative defense against prosecution" and "will hinder child abuse investigation in Colorado.

Colorado Medical Society has worked hard to help educate our physicians to be alert for signs of domestic and child abuse and to report these matters to the proper authorities. I seriously doubt whether that will be allowed to remain in place under Amendment 17.

Colorado Medical Society is concerned that this law will have serious negative consequences on the health and well being of Colorado children.

Jo Blum, Executive Director of Families First and a member of Protect Our Children, says "This amendment is dangerous. It takes away protection for children in abusive families and makes it difficult to investigate and prosecute for child abuse". Ms. Blum added "I work every day with parents who beat, punch, burn, rape and abuse their children. These are the parents who are not taking responsibility... these are the parents who will use the Parental Rights Amendment as a defense against intervention or prosecution." She stated that "the amendment is simply unnecessary for good parents and it is dangerous for children."

CMS physicians voiced strong opposition to this amendment, stating that an amendment to the constitution will wipe out much good work of the past in assuring reporting of suspicious injuries.

The CMS Alliance will be sending a letter to each CMS member asking that Colorado physicians and spouses defeat Amendment 17 at the polls.

Whatever side you come down on, this is an extremely important issue. I chose to write about it because of the lateness of our meeting in September, allowing no opportunity to get the word out.

This is a matter that every CMS member needs to know about and needs to understand the House resolution before election day.

*Extracted from the Board of Directors' Progress Report, Attachment 3, "Parental Rights Initiative". The House adopted to support the **opposition** to this ballot initiative.*

Be it Enacted by the People of the State of Colorado:

Article II, section 3 of the Colorado constitution is amended to read:

(3) Inalienable rights. All persons have certain natural, essential and inalienable rights, among which may be reckoned the right of enjoying and defending their lives and liberties; of acquiring, possessing and protecting property; of seeking and obtaining their safety and happiness; **AND OF PARENTS TO DIRECT AND CONTROL THE UPBRINGING, EDUCATION, VALUES, AND DISCIPLINE OF THEIR CHILDREN.**

D

Domestic Violence Awareness Month

by Ellen Stein, Director
CMS Health Care Policy Department

"Physicians can and do make a difference in stopping domestic violence."

October is Domestic Violence Awareness Month. It remembers those who have suffered from battering, and celebrates those who have survived to make new lives for themselves. According to FBI statistics - a woman is physically battered every 15 seconds in the United States. Children in these homes suffer the psychological anguish of witnessing and often experiencing abuse themselves.

Domestic Violence Awareness Month evolved from the first Day of Unity observed in October, 1981, by the National Coalition Against Domestic Violence (NCADV). The intent was to connect battered women's advocates across the nation who were working to terminate violence against women and their children. The Day of Unity soon became a special week when a range of activities was conducted at the local, state and national levels.

The activities were varied but there was a common theme: mourning those who have died because of domestic violence, celebrating those who have survived, and connecting those who work to end violence.

In October 1987 the first Domestic Violence Awareness Month was held. The first national toll-free hotline was created that same year. In 1989 the first Domestic Violence Awareness Month Commemorative legislation was passed by the U.S. Congress.

Physicians can and do make a difference in stopping domestic violence. Many doctors attempt to educate their patients, while others provide support and information. A few Colorado surgeons have en-

rolled in the National Domestic Violence Project which provides free facial and plastic reconstructive surgery to victims of domestic violence.

The project was created by the American Academy of Facial Plastic and Reconstructive Surgery in partnership with the National Coalition Against Domestic Violence in an effort to try to alleviate some of the pain and scars borne by victims of domestic abuse.

The project has a toll free number, **1-800-842-4546**, that provides the names of surgeons in the victim's area who will provide a free consultation and perform surgery if necessary. Since its official beginning in April 1994, the referral center has received over 10,000 calls and 1,000 women have had surgery performed through the program.

Efforts like the plastic surgery program exemplify the actions that physicians in Colorado take on behalf of their patients every day. Doctor, this month please remember to continue this tradition of patient care and advocacy. Your actions can make a difference in breaking the cycle of violence.

For more information about the reconstructive surgery program please call TK/PR Public Relations at 212-909-0340. For additional information about domestic violence resources please contact the NCADV at 303-839-1852. Or call Ellen Stein at the Colorado Medical Society at 779-5455 or 1-800-654-5653.

Colorado Medicine would like to thank the NCADV for the information contained in this article and for the poster which appears on the cover of this issue.



THE BATTERING

by Ellen Stein, Director
CMS Health Care Policy Department

Between January 1987 and January 1991, more than 500 people were killed in Colorado as a result of domestic violence.¹ In the United States, a woman is battered every 15 seconds.²

There is no profile of would be victims to deter those grim statistics. It happens to women in all walks of life, and it can lead to a tragic syndrome that has been carefully studied by the National Coalition Against Domestic Violence (NCADV).

What is battering? It is a pattern of behavior with the effect of establishing power and control over another person through fear and intimidation, often including the threat or use of violence. It includes emotional, physical and sexual abuse.

Unfortunately doctors cannot cure domestic violence, like battering. As a physician your role is to recognize when it has occurred, treat the injuries, and be a vital resource to your patients for information and further assistance. The Colorado Medical Society (CMS) wants to help you with that role.

Over the course of the next year, *Colorado Medicine* will publish a series on domestic violence. Each month, beginning in December, a pocket calendar will be printed in the magazine. Information on family violence, which you can use in your office, will be printed on the reverse side of the calendar.

CMS also has "**Don't Suffer in Silence**" packets available. Materials include: 1) a poster which encourages patients to talk with their physicians if they are involved in domestic violence; 2) regional resource information cards for your

patients, which indicate available shelters and other resources in your area; 3) a statewide resource referral list for you; and 4) office protocols and information outlining how to intervene with patients involved in domestic violence. These packets are available to CMS members at no cost. There is a minimal charge for additional materials. Nonmembers may obtain information for a small fee.

These materials are being supplied in an effort to facilitate your ability to be your patient's advocate. They provide a means to effectively intervene, on behalf of your patient, in domestic violence.

Physicians may be the first non-family member to whom an abused person turns for help. Studies have shown, however, that while physicians routinely see the consequences of violence and abuse, they often fail, for a variety of reasons, to recognize and acknowledge their etiologies. A Denver based study found that 54 percent of women in emergency departments had experienced some form of domestic violence at some point in their lives. Of those same women, 11.7 percent were seeking care that day because of domestic violence, but only 13 percent of them were actually identified by physicians as victims of domestic violence.³

Physicians cannot single-handedly solve this major social ill. However, doctors are in a unique position to contribute to the prevention of, and intervention in, domestic violence. You **can** be part of the solution.

Questions? Call Ellen Stein at CMS, at 779-5455 or 1-800-654-5653. E-mail Ellen_Stein@cms.org.

"These materials are being supplied in an effort to facilitate your ability to be your patient's advocate. They provide a means to effectively intervene, on behalf of your patient, in domestic violence."

References

1. According to statistics by Project Safeguard. Barb Shaw. Denver, CO. 1991.
2. National Coalition Against Domestic Violence: 1995-96 Fact Sheet. Denver, CO 1995.
3. Abbot J, Johnson R, et al: Domestic violence against women- incidence and prevalence in an emergency department population. *JAMA* 1995;273:179-63-1767.



C.R.O.P. update

by Suzi Shevell, Program Manager
CMS Health Care Policy Department



Peter B. Milstein, CFRE

The Colorado Rural Outreach Program (CROP), a Colorado Medical Society (CMS) directed loan repayment program for rural physicians, has begun. Plans for a feasibility study were made during the recent Colorado Medical Society (CMS) Annual Meeting in Steamboat by the Resource Development Committee of CROP and Mr. Peter B. Milstein, CFRE.

The study, which will involve 50 to 75 personal interviews, will assess the viability of the project. Results will assist program leaders in fine tuning the focus of the project, as well as determining the best methods to raise funds for the CROP.

The Resource Development Committee of the CROP will provide Mr. Milstein with names of corporations, foundations and individuals that will be considered for the interview portion of the market study.

The CMS has contracted with Mr. Milstein, Senior Associate and CEO of Development Associates of Colorado, to oversee the feasibility study. Peter brings 25 years of development expertise to the project. He asks that every CMS member become involved with this effort. *Can we count on you?*

Should you have fund raising ideas, please feel free to share them. Mr. Milstein and staff are anxiously awaiting your input. Call Suzi Shevell in the CMS Health Care Policy Department at 779-5455 or 1-800-654-5653.

How this program works

Interested physicians apply to the CROP for educational loan

repayment assistance. The CROP works with physicians and rural communities to find an appropriate match. If arrangements between a physician and a community are agreed upon, then the physician contracts with the eligible community and the CROP. The CROP and the community provide up to \$20,000 per year for the repayment of outstanding educational loans. (The community provides 50 percent of the loan repayment dollars.) In exchange for loan repayment, the physician will provide health care for a minimum of three years in that rural community.

The CROP was created by the medical society after legislation written by the CMS Rural Health Task Force was killed by the Colorado Legislature. Originally plans were made to secure start-up funds for the administration of a new state educational loan repayment program for physicians, physician assistants and advanced practice nurses willing to practice in rural areas. Since the legislature did not pass the bill, the CMS Board of Directors decided to develop the program on an "in-house" basis by appropriating \$20,000 to begin work. Because of limited CMS resources, the CROP will provide loan repayment exclusively for physicians. It is hoped that the program will be expanded to include other providers in the near future.

The Colorado Medical Society is extremely excited about this unprecedented and worthy program. Much work is yet to be done. We encourage your support.

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Not as important as what's ON the cards.

If you're like most Bridge players, you're always hoping for good cards.

Well, here's one solution: These cards are always good! CMS, in celebration of its 125th Anniversary, has produced these Bridge decks, excellent for gifts or for your personal use, printed with the Colorado Medical Society seal in gold on a red back, they are Bridge size plastic coated linen cards.

They're just \$4.25 per deck including postage and handling. All proceeds go to the Colorado Medical Foundation, so this is one bridge hand that's a win-win-win situation.

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RAM

Recent Affiliations and Mergers (in Colorado healthcare)

Prepared by Lorraine Heth, Program Manager
Colorado Medical Society Department of Health Care Policy

Key: **DP** = Denver Post; **CMC** = Colorado Managed Care Newsletter; **RMN** = Rocky Mountain News; **DBJ** = Denver Business Journal;
WSJ = Wall Street Journal; **C/M** = Colorado Medicine

• FHP, Inc. and PacifiCare

FHP, Inc., the parent company of Colorado's largest health care plan, has been acquired by California based PacifiCare, forming the nation's fifth largest health plan, with health plan operations from Guam to Florida. It will solidify PacifiCare's position as the largest Medicare Risk contractor in the nation with nearly 1 out of 4 Medicare beneficiaries enrolled under HMO Risk contracts. The acquisition is valued at \$2.1 billion and will be a combined cash and stock transaction. **(CMC, 8-12-96)**

• Columbia-HealthONE

Columbia-HealthONE LLC completed the first stage of its consolidation of services at its two Aurora hospitals July 22, when it shifted all pediatric in-patient and emergency care to Aurora Regional Medical Center. Columbia plans on shifting all acute-care services to Aurora Regional over the next two years, turning Aurora

Presbyterian into a sub-acute and transitional care facility. That change is due to be voted on by the system's board of directors in August or September.

(DBJ, July 26-Aug. 1, 1996)

• TriWest

TriWest, a consortium of 13 healthcare insurers and providers has been awarded the CHAMPUS contract for Regions 7 and 8 covering most of the Rocky Mountain West. The consortium was developed by Blue Cross of Arizona and will have headquarters in Phoenix. In Colorado, the group's partner is University Hospital/University Physician, Inc. Sierra Health Systems of Las Vegas is also a partner. Of the 745,000 eligible patients, 132,000 are located in Colorado. **(CMC, 7-8-96)**

• Trends

Ninety-five percent of the country's urban and suburban hospitals have contracts with health maintenance organizations, compared with 69 percent of their rural brethren, according to a survey by Deloitte & Touche, LLP. The numbers of rural hospitals with HMO contracts has increased 24 percent in the past two years, the survey said. Despite managed care's inroads into the nation's health-care delivery

system, few people know what an HMO is, the study found out.

Other results:

- 16 percent of the hospitals had joined larger organizations in the last two years.
- 93 percent of the hospitals have not cut services, and 43 percent have expanded their geographical market.
- 67 percent of the hospitals have physicians on their boards.
- 82 percent of the physicians at their hospitals accept some level of managed care
- 57 percent of the hospitals have implemented outcome-measurement programs in the last two years, and 76 percent say they will have programs in the next five years.

• Other News of Related Interest:

Prudential HealthCare has announced an expansion in its Denver primary care physician network which will nearly double its size to nearly 250 physicians. Prudential is also considering an expansion in the number of Denver hospitals with which it contracts. **(CMC 8-12-96)** In addition, Prudential is re-thinking its relationship with the Denver Health Care Group, a 17-member group of primary care doctors who work exclusively for Prudential. The company is considering allowing the physicians to see patients

(Continued)

(Continued from previous page)

from other plans, according to Mark Donahue, executive director of the subsidiary of Prudential Insurance Co. of America. (DP, 8-2-96)

PhyCor, a physician management company based in Nashville, has achieved a major goal in establishing its first management contract in Denver with the **Focus Medical Group**. It has just acquired Focus' management service organization, Front Range Medical Management and entered into a long term management contract with the group. PhyCor currently has relationships with groups in Pueblo, Boulder, Greeley and Fort Collins. Focus, which was started in 1989, has 70 physicians in multiple locations in South Denver. (CMC, 7-8-96)

Kaiser (Colorado) has been considering expansion along the Front Range for the past year or two and has wrestled with the issues of provider relationships. According to a spokesperson for Kaiser and **Colorado**

Permanente, contracting with outside physicians will be conducted by Permanente. (CMC, 6-10-96) Kaiser could decide by mid-September whether to move into Colorado Springs with up to 100 jobs. Kaiser has also discussed its proposed expansion with physicians' groups in Colorado Springs. (RMN, 8-6-96)

Pediatrix, a national pediatric group, has moved into Colorado with the acquisition of groups representing 20 pediatricians and neonatologists. It is operating as Pediatrix Medical Group of Colorado and its president is Dr. Eric Kurzell. (CMC, 6-10-96)

After extensive discussions between Colorado Health Dimensions (the former Provenant MHO), Columbine Medical Group (FHP's Denver provider group), FHP, and Pacific Health Dimensions (CMC's management service organization), a resolution is being struck. Colorado Health Dimensions (CHD), which is directed by Dr. David Scanavino and Meg Cleary, has been renamed Physician Health Partners (PHP). It continues to represent Northern Health Partners and Superior Health System. PHP reports it will begin to work more closely with Centura. (CMC, 8-12-96)

Quote:

"It has been a zany couple of years in this field," said futurist Jeff Goldsmith, a healthcare consultant from Chicago.

(DP, 7-26-96)

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David C. Martz, MD
President
Colorado Physician Network

What can YOU do for Rocky Mountain Physicians' Choice?

As marketing of Rocky Mountain Physicians' Choice (RMPC) begins in earnest in the Southern Front Range, the Eastern Plains, and the Northwest, our members frequently ask what they might do to assist in the marketing of our program. Although the physician leadership and the staff of Rocky Mountain HMO are working furiously to "Make it Happen", there ARE several vital needs you can address.

1. We need personal contact with potential purchasers. Among your patients, neighbors, friends, or social acquaintances are probably some key employees who influence or make health care decisions in their place of employment. TALK TO THEM about the unique features of RMPC. Then call Kirsten in Denver (303/694-2784) or Denise in Pueblo (719/543-3568) with the name, role, organization and phone numbers so our marketing staff can follow through on your entré.
2. We still need more Primary Care Physicians in the Front Range metro areas. So talk about RMPC to your medical colleagues--especially the Primary Care Providers--and bring your professional comrades on board! If you

need background information, call Kirsten at 303-694-2784, or me at 719/577-2555. We will assist you in any way possible, including sending you a "recruiting kit", and following up on your leads.

3. RMPC is available to you and your office staff. This is an opportunity not to be taken lightly, as physicians and their employees are often high utilizers and thus expensive to insure. We are pleased to offer you this option, with the belief that your participation as recipient AND provider will give you an extra dimension of insight--and modeling--for your patients.

So don't "leave it to George" . . . Make certain it gets done . . . participate personally. We need your involvement, and the sooner the better, the more the better. Call today and "Help it Happen"!!

Addendum

At the Colorado Physician Network Board of Director's meeting on Wednesday, September 25, the following officers were elected:

President

David C. Martz, MD

Vice-president

Thomas Allen, MD

Secretary

Joel M. Karlin, MD

Treasurer

Louise McDonald, MD

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Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Copic to Connect Via the World Wide Web

In response to a growing demand from our policyholders, as well as for a variety of business reasons, Copic Insurance Company is working to create and maintain a presence on the World Wide Web portion of the Internet. According to a recent survey we conducted, approximately 33% of our policyholders currently use the Internet and World Wide Web at least once a week.

In this installment of Copic Comment, I wanted to give you a "sneak peek" into our upcoming website (set to debut November 1), and ask for your feedback.

Copic's website is designed as a service to our policyholders. Its purpose is to give you access to the information you want exactly when you want it. The website, which we plan to locate at <http://www.copic.com> (subject to final URI, registration), will present you with at least the following options:

- **What's New:** Clicking on this option will take you to the latest news from Copic, updated p.r.n. When the website first becomes available, you will be able to see detailed results from Copic's recent "Annual Check-Up" survey under this heading.
- **Copiscope Online:** Visitors who click on this option will have access to every article from the preceding 12 months of publication, indexed by issue, topic, and physician specialty.
- **Seminar Schedules:** When you click on this option, you will be able to browse among schedules for all of the various seminars Copic offers, indexed by type and location. You will also be able to e-mail your

seminar registration directly from this screen.

- **Experience Rating System (ERS):** The ERS has two purposes: first, to ensure that our policyholders have access to important specialty-specific risk management information, and second, to reward policyholders when they continually expand their risk management knowledge. Clicking on this option will lead you to a full description of the ERS, indexed by topic.
- **Products and Services:** Clicking on this option will lead you to basic information about the broad range of products and services Copic offers, including coverages available, discount programs, and support programs.
- **Copic Departmental Contacts:** This option will function as an abbreviated online version of the Copic Telephone Guide, comprising the phone numbers for key contact people in the Claims, Finance/Accounting, Risk Management, and Underwriting departments.
- **Frequently Requested Resources:** When you click this option, you will be able to download and/or print copies of some of the most frequently requested Copic resources, including model consent forms, termination of care letters, and guidelines for records retention.
- **"Back Talk":** Clicking on this option will present you with a pre-formatted e-mail screen so that you may quickly and easily provide us with your feedback and suggestions regarding the website and/or any other Copic program.

The website will offer Copic policyholders a number of distinct advan-

tages. Prime among these are instant access to information (even faster than fax) and the ability to retrieve information any time of day or night (not just during regular business hours). In addition, our strong emphasis on indexing means that you'll spend less time *looking* for what you need -- and more time *finding* it.

Those readers who are Copic policyholders might be interested to learn that Copic is relying on internal resources and staff to create and maintain the website. Our website will be hosted by MEDNET, an Internet Service Provider company headed by Lee Golter, M.D., of Grand Junction.

I'm pleased to be able to share our plans with you. Now it's your turn. Contact us with your ideas and suggestions at:

E-mail

rkmddoc@aol.com

Telephone

303-930-0467 or
800-421-1834, ext. 2467
(Marjorie Anderson,
Communications Coordinator)

Facsimile (FAX)

303-779-8775
(to Marjorie's attention)

Mail

Marjorie Anderson
Communications Coordinator
Copic Insurance Company
7800 East Dorado Place, Ste. 200
Englewood, CO 80111

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— Marilyn Bull, MD, Indianapolis

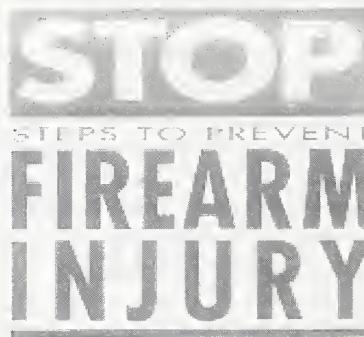
“The materials are effective and practical.”

— Christopher B. Houts, MD, FAAP, Phoenix

“The brochures are the perfect starting point for talking with parents.”

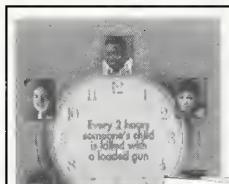
— Michael Clemmens, MD, Annapolis

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Physician's Name

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Return to: Center to Prevent Handgun Violence, P.O. Box 8303, Easton, MD 21601-8303



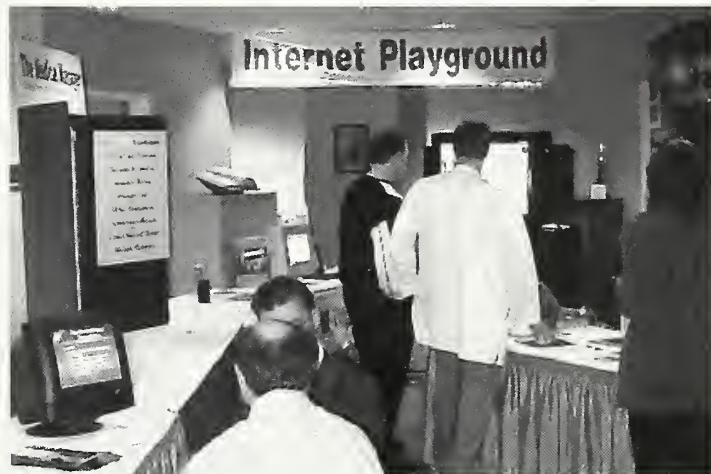
by Chet P. Seward
CMS Communications

'96 Informatics Fair focuses on the Internet

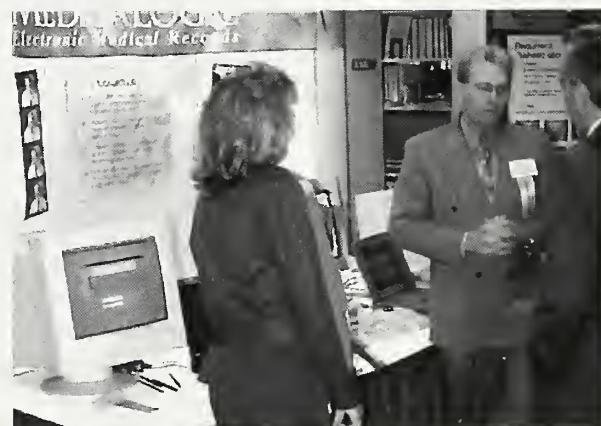
If attendance and interest mean anything, then the annual Informatics Fair held on September 26-27 demonstrated that physicians are seriously considering the impact of new information technology on the practice of medicine. This year's fair, held at the Denver Medical Library, featured the Internet and the way it is both positively and negatively affecting the practice of medicine. A panel of renowned speakers addressed confidentiality, security and malpractice issues surrounding electronic medical records. Others discussed cyberspace turf issues and ownership of information guidelines. A host of exhibitors displayed some of the latest technological advances.

The fair also showcased how new technology can lessen the growing workload of physicians. Doctors are increasingly being asked to manage complex, data oriented tasks that they neither have the time nor the training to master. These new responsibilities, brought on by the constant changes in health care, have caused many doctors concern.

Data is increasingly becoming a commodity. As a result, many doctors are learning that computers may be the tool of choice for the qualitatively effective care that patients and the rest of the industry expect. Forums, like the Informatics Fair, provide physicians with the opportunity to become familiar with the technology that will help shape medicine in the next century.



The Internet playground was a hot spot of activity during the 1996 Informatics Fair. Physicians "surfed the net" for the latest information on reports as varied as practice management guidelines to Wallstreet stock quotes.



Laptop computers were buzzing as exhibitors displayed the newest advances in medical informatics. Above, a physician learns the pros and cons of an electronic medical record program.

by Lee B. Golter, MD
Grand Junction, CO

"The process of ensuring confidentiality of patient information for many physicians has been like scaling an insurmountable mountain."

It has been a long climb. The process of ensuring confidentiality of patient information for many physicians has been like scaling an insurmountable mountain. Preserving privacy has been a tireless battle in an attempt to attain the summit of patient trust. The paper medical record has arguably achieved confidentiality by obfuscation. In many ways, access is limited to those who can actually find and decipher a record with all the necessary patient information. The electronic medical record offers a number of shortcuts to the summit, but it also provides more opportunities to fall off the mountain by the sheer volume of data that can be potentially misused. The following is a discussion of the principles that affect your ability to maintain patient privacy.

The quality of confidentiality is directly affected by what each member of the health care team does to protect it. It is an inverse measure of the ability to obtain critical, individually identifiable information from a health care provider's facility without requisite permission. The more "quality," the harder it is to obtain information without permission.

The methods which form the basis of confidentiality, whatever the media, are the same:

- **Specificity** refers to the method of determining and placing different protection values on data, dependent on the data's role in the care of the patient. For example, certain laboratory tests and psycho-emotional diagnoses have different protection values.

- **Permission** is the method by which an individual or group is authorized to maintain specific patient information. Generally an individual gives an agency permission to direct the release of information.
- **Authentication and verification** simply refer to a doctor's ability to be absolutely sure that both the patient who directs him/her to release information and the receiving agency are who they say they are. In the paper world this process can be quite frustrating. Electronic verification has been proven to work quite well using methods perfected by the financial community.
- **Display** concerns itself with the casual observer's ability to gain information because it is "displayed" and readily available. Sticky notes on terminals with passwords are examples of how confidentiality can be compromised.
- **Storage and ownership** seem to blur together as legal wrangles over these two independent issues continue. Records used to be considered physician property. That no longer is true. To date there is no national standard for ownership and confidentiality of medical records. The Bennett-Leahy Bill (Senate Bill 1360) has attempted to address the protection and privacy of medical records, but it is currently in legislative limbo.

The recently enacted Kennedy-Kassenbaum bill has also tried to address the medical record confi-

(continued next page)

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dentiality debate. The bill, known for its portability of health insurance measures, created standards for electronic claims, enrollment, eligibility and referrals, as well as mandating that the Health and Human Services Department adopt models for unique identifiers for patients, providers, plans and employers. Unfortunately the bill suffers from myopic vision because it creates a national electronic network without clearly defining privacy rules. Fines and imprisonment were included in the legislation for wrongful use of information, but confidentiality standards are lacking.

Clearly it seems like everyone is struggling with confidentiality issues. Access to patient information *should* be controlled by the processes set up in physician offices or clinics which pay particular attention to the principles above. The increase in electronic exchange, including fax and telephone, has augmented the ability to access data in unauthorized ways. The advent of electronic networks and computerized patient records amplifies the problem because any breach can be potentially exploited by releasing volumes of information that may not even be detected.

Recent and pending legislation will inevitably advance the electronic medical record front. Decisions to use paper or electronic medical records should be based on what is best for you and your practice. The principles of confidentiality outlined above can pragmatically guide that decision.

Today the climb can and must continue. The proper application of the methods described above, providing steps for the distribution, storage and display of sensitive information, will allow the material to be kept secure. It will also allow those with proper permission to have easy access.

It's 9:00 p.m. and you're just starting rounds at the hospital.

You worked from 8:00 a.m. till 10:30 p.m. yesterday. You can't remember the last full weekend you had off. This week you've diagnosed two patients with cancer, watched two die, and broke the news to all four families. On top of it all, recent developments make you wonder if you can stay in private practice.

You're bright and very good at what you do — taking care of the physical needs of your patients. But there's no getting around it; the medical profession is changing — *and challenging*.

I'm good at what I do, too. I'm a clinical psychologist, and I've worked with many doctors in my 25 years in this field. I team up with people, *including physicians*, to help them put things in perspective — professional demands, family relations, life style, etc.

Want a new team member?
Call me. I'd like to help.

303-651-9290

Michael Smith, Ph.D.

- Private practice, 1983 to present
- Faculty, The Naropa Institute, 1996
- Faculty, Institute of Transpersonal Psychology, 1983-1996
- Workshops for physicians
 - *Handling Your Own Grief*
 - *Dealing With Patients' Emotions*
 - *Understanding Depression*
 - *Handling "Practice" Stress*

Colorado Medicine for October, 1996

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The Choice Is Theirs

A video for physicians on Advance Medical Directives making End-of-Life Decisions

Are physicians well-informed and knowledgeable about Advance Medical Directives? Patients think they are, but some surveys indicate that many physicians don't know or understand current laws. *The Choice Is Theirs* video is specifically designed to walk the physician and his/her staff through the laws and their many features.

In an effort to assist the medical community and the public with questions on Advance Medical Directives, a consortium was formed. The goal of this group is to help educate all involved about these personal issues. The consortium includes: the Colorado Springs Osteopathic Foundation, Memorial Hospital, the Penrose-St. Francis Healthcare System, the Colorado Hospice Organization and Gonzaga University Television.

The Choice Is Theirs, a video about advance medical directives in the State of Colorado, (Living Wills, Medical Durable Power of Attorney and CPR Directives - Cardiopulmonary Resuscitation Directive) features Colorado and national experts from the legal, medical and medical ethic communities who answer the following questions:

1. What are advance medical directives as described in Colorado law?
2. What do these documents do for the patient and for the doctor?
3. When should advance directives be discussed with patients and families?
4. Who should have advance directives?
5. Where can the appropriate documents be obtained?

The Choice Is Theirs will be extremely helpful to the doctor, medical office staff, healthcare professionals, nursing educators, attorneys, and others. The video is a companion to "The Choice Is Yours", a video produced for the general public, patients and their families. The two videos complement each other, one directed to physicians and the other to the public/patient/families.

To order your copy of *The Choice Is Theirs*, fill out the following order blank. Allow up to four weeks for delivery.

Name _____ Phone () _____

Address _____

Number of videos ordered _____ (\$25.00 each, including postage & handling) **Total \$** _____

MAKE CHECK OR MONEY ORDER PAYABLE TO: Colorado Springs Osteopathic Foundation (719) 635-9057
(MEMO: Advance Directive Video)

MAIL ORDER FORM AND PAYMENT TO:

The Choice Is Theirs (Video for Physicians)
Health Resource Center
The Penrose-St. Francis Healthcare System
P. O. Box 7021
Colorado Springs, Colorado 80933



John L. Lightburn, MD
Historian
Colorado Medical Society

"The White Plague" and Dr. Webb.

"Our natures are the physicians of disease."

Hippocrates

"By the historical method alone can many problems in medicine be approached profitability."

Sir William Osler

Our story begins many centuries ago when a rod-shaped bacterium, now called *Mycobacterium tuberculosis*, evolved as an infectious agent in man and beast. As man developed communities and migrated restlessly, the bacterium also migrated, spread by droplet infection. The disease it caused (called phthisis by the Greeks) became endemic throughout much of the world, especially in the northern Eurasian continent. In the 18th and 19th centuries, the industrial revolution created crowded and polluted cities. These conditions converted the endemic tuberculosis into an epidemic. A real killer, insidious and gradual in onset, it literally consumed the body. Victims wasted away, and death came in frightening numbers. It was the number one cause of death in Europe and North America in the 18th and 19th Centuries.

The medical profession, ignorant of its cause, offered many theories and therapies described in many learned papers and medical books. Benjamin Rush, professor of clinical medicine at the Medical School of Philadelphia published four volumes which included three on pulmonary consumption. In the first paper, "An Inquiry into the Cause and Cure of the Pulmonary Consumption," he describes the efficacy of table salt in the cure of hemoptysis.

"The mode of giving it is to pour down from a tea- to a tablespoonful of clean, fine salt as soon as possible after the hemorrhage begins from the lungs. This quantity generally stops it; but the dose must be repeated daily for three or four days, to prevent a return of the disease."

Dr. Rush may have become discouraged by the lack of response in his consumptive patients. He later became known for his interest in mental illness. Today, he is called the father of American psychiatry.

Despite the best efforts of the profession, the "White Plague" became more prevalent as western culture became more urbanized. In the hundred years after Rush's publication, the work of scientists like Jenner and Pasteur created the beginnings of the science of bacteriology. In 1882, Robert Koch announced his discovery of the *Tubercle Bacillus*. But control of the "White Plague" eluded the profession as it continued to debate the validity of the germ theory of disease. Advising a move to a better climate was about the best the physician could offer his tubercular patient.

This was the advice to young Gerald Bertram Webb in 1894 when he brought his bride of eleven months to Dr. Goodhart, London's best chest specialist. "Jenny", Dr. Goodhart said, "has phthisis and you must leave London immediately for a warmer, dryer climate." And leave at once they did with Gerald giving up his studies as a medical student at Guy's Hospital and sailing for the United States and Jenny's family who lived in Philadelphia. After a brief visit with old friends and relatives, they moved on, to the Piney Woods Hotel in Thomasville, Georgia, where her consumption did not show the immediate improvement Gerald had hoped for. Restless and pressured by Jenny's unhappiness and mounting debt, he decided to move to Colorado Springs, known as a mecca for consumptives and also the "Newport of the West". Here his beloved Jenny could find a quick cure without being deprived of the social life she had enjoyed in Philadelphia. Indeed both of them were delighted with the resort of Manitou Springs, living with the rich and famous of that time.

Realizing Jenny's recovery would take longer than originally planned, Gerald postponed his dream of returning to Guy's Hospital and applied for admission to the University of Denver Medical School, beginning his studies in September, 1895. He was stimulated by the lectures and laboratories, especially the course offered by Henry J. Sewall, professor of physiology. With a Ph.D. from Johns Hopkins and research experience in

(Continued)

Cambridge, Leipzig and Heidelberg, young Sewall had become Chairman of the Department of Physiology at the University of Michigan, where he did pioneering work on immunology. After a short time there, he developed the early symptoms of tuberculosis, a diagnosis he confirmed by examining his own sputum. Pressured by colleagues to move to a better climate, Sewall accepted an invitation to come to teach by the dean of the medical school, Dr. Samuel Fisk, at the University of Denver. Fisk, a graduate of Harvard Medical School, like many other physicians, had come to the Rockies in search of a cure for his tuberculosis. Gerald Webb's experience with Sewall gave him his earliest concepts of immunity and gave him the foundation for his research for which he became famous.

After receiving his M.D. degree, Webb returned to Colorado Springs where he set about to establish a practice, not an easy task in the competitive environment of 1896. There were over sixty physicians vying for patients in Colorado Springs. But he was resourceful in establishing a good name with contacts and successful diagnoses and therapies. One of his earliest successes was diagnosing and treating several cases of syphilis which had been mistreated by other local physicians. He presented a paper on exophthalmic goiter to the El Paso County Medical Society, and presented a lecture in physiology to the students and faculty at Colorado College. This resulted in an introduction to Florian Cajori, professor of physics and mechanics. Cajori was experimenting with a Crookes tube which produced the newly discovered Roentgen rays. He suggested that this new technology might be useful in medicine. Might be useful!! Gerald immediately saw the possibilities and ordered a small x-ray machine from Boston, becoming the first radiologist in the area.

At about the same time, Gerald attended a medical society lecture by Dr. W. B. Fenn on the diagnostic usefulness of examination of the blood. He had learned this from Dr. Sewall in Denver and, encouraged by his new friendship with Dr. Fenn, he set up a laboratory for hematological and bacteriological tests. The community was impressed. Here was a doctor on the cutting edge. With these innovations, his practice grew and thrived. Gerald Webb, however, was not only a scientist; Webb was also a humanitarian, a physician with a keen insight into his patients' emotional lives and an empathy for their fears and suffering.



*Gerald Bertram Webb, MD
(circa 1945) at his home
1222 No. Cascade, Colo. Springs*

In a letter to his mother, he wrote, "The whole art in the successful treatment of consumption is in administering to the mind." He became as well known for his art as for his science.

As Gerald's practice thrived, Jenny's health declined. All of his art, skill and knowledge were to no avail as he watched the tuberculous process consume his beloved Jenny. She died on July 16, 1903, nine years after first learning of her disease. Gerald was devastated by his loss. Friends tried to comfort him, took him to Glenwood Springs to rest, invited him to parties and called on him. But he was inconsolable. For months, he remained isolated

and aloof. He was urged by his family to return to England, but he could not until his debts were paid, debts incurred by his life style of his country club, polo ponies and large house, and a reluctance to collect fees for his professional services. In spite of his indebtedness, he paid little attention to practice. Eventually he found peace and solace in the home of Addison Hayes where he enjoyed the company of young Jefferson Davis Hayes. The Hayes family was a comforting family and their daughter, Varina, became interested in the young Englishman. His emptiness was relieved by this bright, cheerful woman and they soon were in love and married on July 30, 1904. Addison Hayes' wedding gift to his daughter and new son-in-law was a "princely" home at 1222 North Cascade. With Varina's help, his practice again thrived.

In the fall of 1905, a young boy was brought to the office with a painful abscess. Dr. Webb lanced it but also cut a finger of his left hand. Within six days, Dr. Webb was ill with pustules on the left arm and a generalized septicemia with a high fever and delirium. Five local physicians agreed he could not be saved, but Dr. Charles Powers of Denver was called and he was saved. Weakened by the infection, Dr. Webb was ordered to take an extended vacation, so Gerald, Varina and their infant daughter sailed for England where he hoped to rest and also to take some post-graduate courses at Guy's Hospital.

In London, he discovered that the best course in town was not at Guy's but at St. Mary's Hospital where Almroth Wright was making exciting advances in the fields of immunology and bacteriology. Gerald's spirits soared as he learned exciting new concepts from this scientific giant whose work on a factor in the serum that aided the leucocyte in destroying the bacteria, a factor he called opsonin. Webb enjoyed this stimulating scientist whose work gave him the foundation for his own research. While there he met an assistant to Wright,

ARCHIVES (Continued)

Alexander Fleming, who decades later received the Nobel prize for his discovery of penicillin. Completing his studies, he returned to Colorado Springs where he found himself in demand for consultations and appearances at local and national medical meetings. His knowledge of immunity, vaccines and the opsonin index had made him famous. The Denver Academy of Medicine invited him to present a paper and offered him a nonresident fellowship.

In 1907, he established the Webb Tuberculosis Research Laboratory with the assistance of Dr. William Williams, who had come to Colorado to bring his tubercular wife to Dr. Webb for treatment. While working with "Willie" one evening in December, he received a call from Mrs. Tom Walsh, wife of a millionaire miner,

telling him that she had arranged with the Rock Island Railroad to take him by express to Kansas City to care for her nephew who was dying with typhoid fever. As the only passenger in a single Pullman car behind the fastest engine on the road and a clear track, they left Colorado Springs at 11:00 p.m. and arrived in Kansas City the next afternoon at 2:00. He was able to save the boy and the Webb express was front page news throughout the nation. Webb's fame and fortunes grew as did his laboratory, which eventually became the Webb Institute. He continued his research, travels to medical meetings and continued his practice where he was much sought after.

In 1937, he was asked to go to New York to consult with a patient at Doctor's Hospital. While conducting the consultation in the patient's room, Webb collapsed with a myocardial infarction. So a two hour

consultation became a six week hospitalization and a three month convalescence in a cottage on a sand dune in Southampton. Returning to Colorado Springs, he resumed his work on a much reduced basis, devoting a lot of time to studying pre-Columbian artifacts for evidence of tuberculosis. In June, 1938, he received an Honorary Doctor of Science degree from the University of Colorado, presented to him by his old friend, Dr. James J. Waring.

He continued to live quietly at 1222 North Cascade with his daughter, writing and studying and receiving visitors. He gave his final illustrated lecture to the Climatological Society shortly before he suffered his second heart attack. Spending his last days answering letters and Christmas cards, he died about midnight on January 27, 1948. He had won the battle over the "White Plague".

Physician Recognition Awards

The Colorado Medical Society joins the American Medical Association in recognizing the following physicians for their dedication to excellence in the profession of medicine, as demonstrated in their commitment to continuing medical education.

Pamela R. Abrams
Randall Dwight Bass
Christine Maria Best
Richard Hsiao Chen
David Alan Dassenko
Linda Carol Davis
William Emil Emeis
Richard Owen Evans
Dianna Lynne Fury
Kent Elmo Gay
William Howard Graham

Ingrid M. Hagen
John Sloan Heavrin
Mark Wallace Hinman
David Hipkin
Bryan Anthony Hynes
David Maxwell Kleinman
Elizabeth Sandra Kraft
Randy S. Large
Martin Danl McDermott
Mary Therese McEnany
Lucien T. Megna

Howard Eldon Netz
Theodore J. Puls
Thomas Richard Sanford
Richard A. Scheuring
Leslie Beth Shapiro
Larry Homer Smith
Christopher S. Stanley
James Michael Swinehart
Lisa Marie Toepp
Christopher Norman Tulin

rocky mountain

HEALTH CARE OBSEVER

information for decision makers



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delivers in-depth coverage on
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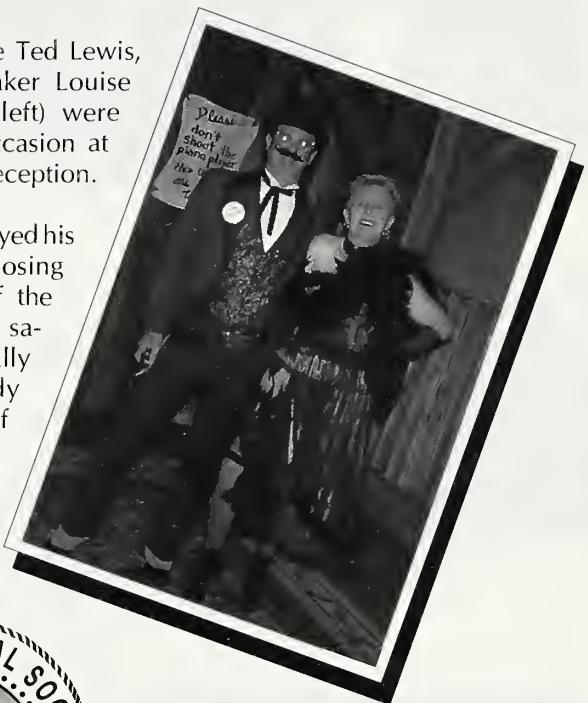
One-hundred, twenty-five years by and for Colorado Physicians!

It was the 126th Annual Meeting, commencing this 126th year of the Colorado Medical Society. We looked back, and we looked forward. . . at the practice of medicine. Along the way, we had some fun with appropriate recognition and a well-oiled machine (House of Delegates) which accomplished a lot.



Speaker of the House Ted Lewis, MD, and Vice-speaker Louise McDonald, MD, (left) were dressed for the occasion at the pre-meeting reception.

The Speaker played his part (right), posing with "one of the girls" in the saloon (actually it is Sandy Finney, of the CMS staff)



Dr. Gary D. Vander Ark, (left) from Arapahoe Medical Society, accepts the charge of President-elect. He was opposed by Dr. Thomas Allen, of Larimer County.

Speakers (right) looking into the future, Vice Speaker of the House Louise McDonald, MD, and Speaker Ted T. Lewis, MD, were in "Star Trek" regalia for the Presidential Inauguration Saturday, September 21st.





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Snapshots from the 126th CMS Annual Meeting

Dr. Painter accepts a handshake from Dr. Karlin (bottom left) after he is officially sworn in as CMS's 126th President. Leanne Kaiser Carlson (left) captivated the House of Delegates with a keynote speech which emphasized that computer technology is a tool that physicians must use. Drs. Dwight C. Dawson, John F. Mueller, Robert McCurdy, John H. Donnelly, Aloysius I. Rowan, Jr., William R. Cook, and John Lightburn, (top left) celebrating 50 years as practicing physicians stand tall as Dr. Karlin pays them tribute. In his first official act as president, Dr. Painter presents Dr. Karlin with the CMS Certificate of Service (top right). Later, Dr. Painter and wife Lynn (below) take a break from the festivities at the inaugural dinner dance.



Proceedings of the House of Delegates Annual Meeting 1996

The Colorado Medical Society House of Delegates met at the Sheraton Steamboat Resort, Steamboat Springs, Colorado, September 20 - 22, 1996 and took the following actions:

REFERENCE COMMITTEE ON BOARD OF DIRECTORS/CONSTITUTION & BYLAWS

Adopted a Resolution to sunset the Nominating Committee.

Adopted a Resolution to establish forums made up of various practice modes and also entitle them a delegate to the Colorado Medical Society House of Delegates.

Adopted a Resolution which called for the Colorado Medical Society to assist the various component societies, if asked to do so, in establishing accounting policies and procedures and to possibly obtain a master Directors and Officers insurance policy to be extended to cover the component societies.

Adopted a Resolution which called for the Organizational Study Committee (OSC) to study the possibility of payment to officers, members of the Board of Directors, and Chairs of the councils, committees, and task forces. OSC is to report to the House of Delegates at the 1997 Interim Meeting.

Adopted a Resolution to support legislation during the 1997 Colorado Legislative Session to increase the payment of funds to the Colorado Physician Health Program up to \$50.00 per year as part of the physician licensure fee.

Referred to the Board of Directors for additional study, a Resolution which called for the hiring of a part-time Vice President for Medical Affairs. The House requested the Board to report back at the 1997 Interim Meeting.

Accepted for filing:

- Progress Report - AMA Delegation
- Progress Report - Board of Directors
- Progress Report - Executive Director
- Progress Report - CMS Education & Research Foundation
- Progress Report - Organizational Study Committee

Extracted from the Board of Directors' Progress Report, Attachment 3, "Parental Rights Initiative".

The House **adopted** to support the opposition to this ballot initiative. The Women in Medicine Section will be sending out letters to the membership to ask for their support to the opposition.

Extracted the Organizational Study Committee Progress Report and **adopted** a recommendation increasing the honorarium for the President and President-elect.

REFERENCE COMMITTEE ON HEALTH AFFAIRS

Adopted a Resolution which stated that the Colorado Medical Society should be accredited by the Committee on Professional Education and Accreditation until the Accreditation Council for CME provides or endorses an alternative program.

Adopted a Resolution adopting the AMA Policy relating to the granting of privileges to physicians by Colorado Hospitals. The policy states that (1) individual character, training, competence, experience and judgment should be the criteria for granting privileges in hospitals; and (2) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria.

Adopted a Resolution for the Colorado Medical Society to support the position that any revision, destruction, incision, or other structural alteration of human tissue by lasers is the practice of medicine.

(Continued)

Proceedings of the House of Delegates

Reference Committee on Health Affairs *(Continued)*

Adopted a Resolution that called for the Colorado Medical Society Leadership and the Colorado Medical Society Alliance to encourage membership in COMPAC/AMPAC.

Adopted a Resolution which called for the Colorado Medical Society to support the restriction of tobacco industry funding for tobacco-related research.

Adopted a Resolution for the Colorado Medical Society to encourage managed care plans to provide primary care services at the town or city nearest the patient's residence.

Adopted a Resolution that the Colorado Medical Society support the Drug Enforcement Administration (FDA) in opposing the health insurance industry's requirement that physicians provide their FDA registration numbers on all prescriptions for identification and reimbursement purposes.

Adopted a Resolution that called for the Colorado Medical Society to encourage managed care organizations to standardize their drug formularies.

Adopted a Resolution creating specific guidelines ensuring uniformity in how a physician office assessment should be conducted.

Adopted a Resolution that called for the Colorado Medical Society to determine the feasibility of providing counter-advertising such as disclaimer placards and stickers. The placards and stickers will state that the physician does not support the use of any tobacco products or the advertising of tobacco products.

Adopted a Resolution that called for the Colorado Medical Society to support and encourage the American Medical Association to support confidential Human Immunodeficiency Virus (HIV) testing to all pregnant women at the earliest prenatal visit.

Adopted a Resolution that the Colorado Medical Society pursue a policy statement from the Colorado Board of Medical Examiners that only Medical Doctors or Doctors of Osteopathy licensed in Colorado can issue utilization review decisions.

Adopted a Resolution that called for the Colorado Medical Society to adopt the "Prudent Layperson" definition of a medical emergency and to advance the definition through the appropriate committees.

Adopted a Resolution that called for the Colorado Medical Society to support and develop legislation that requires full disclosure of health benefit plans to potential enrollees.

Adopted a Resolution to amend COMPAC policies.

Adopted a Resolution to sunset legislative policies.

Adopted a Resolution to amend the Advanced Directives Policy.

Adopted a Resolution to amend the Governmental Immunity Policy.

Adopted a Resolution to amend the Religious Exemption to Child Medical Neglect Policy.

Adopted a Resolution to amend the Medically Indigent Policy.

Adopted a Resolution that called for the Colorado Medical Society to request its AMA Delegation to submit a

(Continued)

Continued

resolution to establish an independent congressional task force to investigate the manner in which the Health Care Financing Administration (HCFA) implemented the Resource Based Relative Value Scale (RBRVS) and physician payment reform.

Adopted a Resolution that called for the Colorado Medical Society to sponsor and support legislation to allow schools and day-care establishments the right to dispense non-prescription medication to children, with parental consent

Adopted a Resolution that requested the Colorado Medical Society to urge managed care organizations to provide patients and physicians with an explanation of their gatekeeper model. This Resolution also directs CMS, in cooperation with the Colorado HMO Association, to obtain data to compare various gatekeeper models.

Adopted a Resolution that requested that the Colorado AMA Delegation take a resolution to the 1996 Interim Meeting to request that the AMA reaffirm its mission is in support of physicians and patients. This Resolution also asks that the AMA, through their actions, not force physicians to pay high fees, copyright fees, etc., to obtain information contained in documents released by HCFA regarding rules, regulations, and policies.

Adopted a Motion from the Board that requested that the Colorado Medical Society recommend to the Division of Workers' Compensation that the Division comply with the state and federal regulations regarding peer review.

Adopted a Motion from the Board which requested that the Colorado Medical Society support the concept of limiting the total number of United States residency positions.

Adopted a Resolution which called for the Colorado Medical Society to affirm its opposition regarding limitations to health care benefits for psychiatric patients.

Referred to the Board of Directors a Resolution which called for the imitation of using the words "specialist" and "specializing", either in print or in promotional material.

Referred to the Board of Directors for study, a Resolution which called for the Colorado Medical Society to sponsor and support legislation to enable free access to qualified physicians when a worker becomes ill or injured while on the job.

Referred to the Board of Directors for decision, a Resolution which called for the Colorado Medical Society to encourage the Colorado Board of Medical Examiners to adopt a physician-patient relationship statement similar to that adopted by the California Board of Medical Examiners.

Referred to the Board of Directors for decision, a Resolution which called for the Colorado Medical Society to request that the Colorado Board of Medical Examiners convene a committee to examine the quality of care in the managed care environment.

Accepted for filing:

Progress Report - Board of Directors, Attachment 4
Progress Report - Health Affairs Council
Progress Report - Council on Legislation
Progress Report - COMPAC

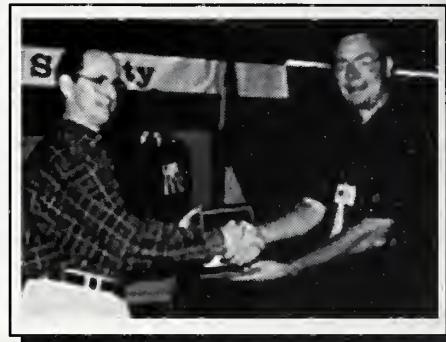
Extracted from the Board of Directors Progress Report, Attachment 4, and **adopted as policy**, were "Recommendations for Transition of Care", the concept in the paper titled "Individually Selected and Individually Owned Health Insurance System", the "Uniform Health Plan Disclosure", and Guarantee Issue of Individual Health Insurance.

Snapshots from the 126th CMS Annual Meeting

Colorado Medical Society staff members Tim Roberts and Edie Register received Distinguished Service Awards for their outstanding work on behalf of the society over the past year. Typically one staff member is given the Distinguished Service Award at the Annual Meeting. The choice proved to be too difficult this year.



Edie Register (photo at left), Director of the Division of Health Care Financing, and Tim Roberts (right photo), Director of Membership Information Services, are shown accepting plaques from CMS President Dr. Joel Karlin. Dr. Karlin said this was a banner year concerning the efforts of CMS staff, and Register and Roberts were at the head of their class.



Denver Medical Society President Donald Eckoff, MD, surprised the 1996 Annual Meeting attendees in the General Membership meeting by a presentation he made to Colorado Medical Society President Joel Karlin. Dr. Eckoff's comments followed a video presentation on CMS' 125 year history, with some of the highlight photos and events over the years. The presentation started with the first President of Denver Medical Society, also

celebrating 125 years. Dr. Eckoff said that DMS (Denver Medical Society), in conjunction with its move eight years ago to its present location, found several certificates in a box in a storage room. These certificates, he said, did not belong to DMS, but instead they were the property of CMS. He said "They are the original Articles of Incorporation and original Bylaws" when CMS filed with the Colorado Secretary of State.



Dr. Eckoff read from the Articles: "This is the first (CMS) Mission Statement: 'The object of the Society shall be to promote the usefulness, honor and interest of the medical profession to enlighten and direct public opinion in regard to the duties, responsibilities and requirements of medical men; to insight and encourage emulation and concert of action in the profession of medicine; and to facilitate and foster friendly

intercourse between those who are connected with the profession; and to promote a fusion of useful information pertinent thereto.' Our original Mission Statement."

With that, Dr. Eckoff presented the historic papers to Dr. Karlin and to Colorado Medical Society. The papers were signed by the Secretary of State on November 1, 1888.

We salute the 32 exhibitors who help make the Annual Meeting possible. Each came with information complementary to medical practitioners, and were well received.

Apria Health Care
Blue Cross/Blue Shield of Colorado
Boulder Community Hospital/
Mapleton Center
Colorado Air National Guard
Colorado Foundation for Medical
Care
Colorado Physician Network
Columbia Spalding Rehab.
Copic Insurance Co.
Corning Clinical Labs
Gadian Corporation
Glaxo Wellcome
Hoechst Marion Merrill Dow
Hospice of St. John
HWC Group/Merrill Lynch
I.M.S. Medacom
Key Bank
Krieger & Associates
Medical Group Management Assn.
Mountain Health Care Systems
NovaCare
Poudre Valley Wound Care Center
Rocky Mountain Fleet Associates
Roche Laboratories
Schering
The Doctor's Company
The Financial Group
U.S. Army Reserve
Valley Home Health Services
Versyss, Inc.
Wyoming Air National Guard

COLORADO MEDICAL SOCIETY

DELEGATE ATTENDANCE

126th Annual Meeting
September 20-22, 1996

Arapahoe

Bartlett, Max
Bublitz, Deborah
Capek, Richard
DeLine, James
Dwoskin, Joseph
Germer, Nancy
Gulevich, Steven
Hanna, Philip
Jolly, Susan
Knize, David
Kortz, Allan
Krauth, Lee
Larkin, Thomas
Lazarus, Jeremy
Levine, Mark
Martin, Cindi
Monheit, Peter
Schreiber, David
Shaw, Cameron
Stecher, Karl
Stienmier, Richard
Truitt, Leigh
VanderArk, Gary
Vernon, Walter
Winter, Clara

Aurora-Adams County

Gottula, Roderic
Greos, Leon
Heaton, Angeline
Heaton, Carl
Manguso, Robert
Matthews, Joseph
Morales, Miguel
Rich, John
Sherman, Eugene
Spaulding, Harry
Sundland, Barry
Unrein, Christopher
Visconti, Paul

Boulder County

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Health Department wants HIV counseling and voluntary testing for pregnant women

The Colorado Department of Health and Environment officially endorsed the Centers for Disease Control and Prevention recommendation that called for voluntary HIV testing of all pregnant women and their infants.

The proposal suggests that health care providers counsel pregnant mothers and encourage testing for HIV infection. This recommendation comes on the heels of a study of HIV infected women that found that AZT (zidovudine) reduced perinatal HIV transmission by two-thirds. Any testing in Colorado must be done on a voluntary basis according to state law. Pregnant women who continue high-risk behavior should be tested again in the third trimester of pregnancy.

Counseling should include explanations about HIV infection and the risk for perinatal transmission of the disease. If tests are positive, counseling should also include therapy options and prognosis reports for both mother and infant. Specifically information about ZDV therapy and the risk of HIV transmission through breast feeding should be supplied.

The CMS passed a similar resolution at the 1996 Annual Meeting which was based on AMA policy.

New free educational program for cancer care

The newly formed not-for-profit Solid Tumor Oncology Education Foundation has announced that it will offer free educational programs on current cancer care treatments to community-based oncologists and other health care professionals.

The Solid Tumor Oncology Education Foundation was established in 1996 to provide physician education, with the express goal of improving the quality of care for cancer patients with the most common solid tumors. The programs will focus on breast, colorectal, gastrointestinal, genitourinary, gynecologic, pancreatic and lung cancers, along with adjuvant and palliative therapy, current and new protocol regimens, screening and diagnosis, and quality-of-life issues.

The educational programs will utilize lecture style seminars and interactive telephone audioconferences. The lecture series and audioconferences will focus on disease-specific diagnoses, patient management, therapy selection, medical outcomes, and quality-of-life issues.

For more information please call 1-800-223-8978.

AMA persistence brings new antitrust rules

Thanks to steadfast lobbying efforts and lots of grassroots support from physicians like you, the American Medical Association (AMA) succeeded in persuading the Federal Trade Commission and the Department of Justice to change their antitrust enforcement policies.

Dr. Daniel H. Johnson, Jr., AMA president, noted that "the revised guidelines should result in more choice for patients, more competition, and better health care".

The revised guidelines addressed three specific physician sponsored issues:

- They acknowledged that patients can benefit from physician designed and controlled ventures.
- Physician joint ventures will not be held as unlawful "per se" simply because they do not reimburse physicians under a capitation mechanism. Fee for service and other kinds of ventures may now demonstrate their merits under a "rule of reason" test.
- Federal agencies will not block joint ventures with 50 percent of physicians in a competitive marketplace.

The new guidelines spotlight a three year campaign by the AMA, which was vociferously opposed by the insurance industry, to increase patient choice.



CHA revises Consent Manual and Guidelines for Release of Health Information

The Colorado Hospital Association (CHA) has revised and updated the 1996 *Consent Manual*. Eight of Colorado's most prestigious health law firms have updated the book to reflect federal and state legislative and regulatory changes.

The *Consent Manual* is a valuable reference tool containing information on federal and state laws and regulation regarding admission, consent for treatment, treatment of patients, and the reporting and release of health information to patients and third parties.

The index in the manual has also been revised to aid in locating new topics. Key chapters include: requirements and basic information for consent; emergency medical conditions; admission agreement and consent for medical treatment; consent to operation or other procedure; advance directives; release of medical record information; release of medical record information to law enforcement agencies and responding to legal process.

CHA members may purchase the book for \$150. Non-members pay \$250. CMS members can take advantage of a *special offer* of \$200 until December 15, 1996.

Physician biographical information now on AMA web site

The American Medical Association has published the first nationwide database of all licensed physicians on the Internet. The database lists a physician's education, residencies, board certification and other significant biographical information available. Patients can search the database by physician name, location or specialty.

This new on-line service, called *AMA Physicians Select*, taps into the burgeoning potential of the Internet as the up-and-coming information/communication vehicle of choice for physicians and patients. "We expect 30 to 50 percent of patients to use the Internet at home or in local libraries to find out more about their physicians," said Dr. Richard Corlin, speaker of the AMA House of Delegates. The program provides the physician's name, address, phone number, gender, medical school, all residency and internship information, specialty board certification and AMA membership.

AMA members have the opportunity to have an "expanded" web listing by displaying things like practice philosophy, health plans accepted, hospital privileges, group practice affiliations, personal information, practice hours and even a photo. Patients can quickly identify AMA members by the logo accompanying physician names. Recipients of the AMA Physician's Recognition Award for continuing medical education are also highlighted.

CMS offers a new coding manual

The Colorado Medical Society (CMS), in cooperation with Physician Reimbursement Systems (PRS), is now offering a solution to outdated, expensive coding manuals. The *SourceBook* provides updated coding information on changes, tips, warnings and advice for Medicare and private payers.

CMS members can now purchase *Coding and Reimbursement SourceBooks* for a substantially discounted price. HCFA's Correct Coding Manual (without any updates) costs approximately \$200. The PRS *SourceBook* is available to CMS members for the special price of \$132. This invaluable resource book is updated three times a year and includes the HCFA Correct Coding Initiative. Nonmembers pay \$184, plus \$15 for shipping and handling.

A letter explaining the *SourceBook* in further detail will be mailed to all CMS members this month. Order forms will be included. If you have any questions, or if you would like to learn more about the *SourceBook* now, please call Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 or 1-800-654-5653.



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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor
Colorado Medicine
P.O. Box 17550
Denver, CO 80217-0550

About last month, from Dr. Gus Garcia

Dear Bill:
I enjoy your letters in the Bulletin, however in the Sept. issue the CSHS was started in 1861, long before Hart and Rogers were on the scene. They played a vital role in the first half of this century. Keep up your excellent letters.

Sincerely
Gus

Yes, my error, and I tip my hat to all those people who have so graciously supported the Colorado State Historical Society. There's much more to CSHS than James Rogers and Stephen Hart, and use of the term "created" was blatantly erroneous. In his day, anything Jim Rogers did could make the young and innocent (me) think he was the father of creation. I got carried away.

About now:

After another CMS Annual Meeting I've reflected on what the past has produced and examining future promises. However, I also have come to believe that some things never change. A number of times during each of these meetings I ask myself, "Why does this happen this way?" And I am reminded of the time I asked Dr. Peter Hoch the same question about some organizational happening. He said "That's how these organizations operate."

Mentioning Peter Hoch reminds me of another note I had to myself: After working with Dr. John Lightburn (CMS Historian) for the past

year, I have become even more aware of our wonderful archives. But the fear lingers that we may lose this element of the organization very soon; there may be no tangible history of Colorado Medical Society physicians from a certain time forward. Yes, we have excellent individual member records from the beginning of this organization until . . . (and this is the part that bothers me) . . . until all of the members became digital entries in a computer data base. The warmth of an individual file on each CMS member, from birth until now has disappeared. From 1978 forward we have had membership files on computer. Few of those computer files contain the subject member's picture. Nor has any of the news clippings about the individual's successes or failures made it into these computer files. Very few personal attributes can be retained in such digital form. That's progress.

In 1963, Dr. Bradford Murphy commenced a decade-long effort, gathering member data and materials to be placed in individual files.

For instance, I remember Peter Hoch who was born in Basil, Switzerland, graduated Columbia Univ., did his internship and residency in the Panama Canal Zone. These were unique, memorable facets of his person. He was a physician, but he was also a husband and a father, and an accomplished artist and sculptor. Fortunately, I knew him that well. Few people outside his own family will have that luxury.

I don't mean to memorialize one person; I merely offer an example of the richness of our unwritten history, a period of the organization which I

can see fading into nothingness because of the lack of personalization. What period, you say? It is the period from 1975 to 1996 (and beyond, I suppose). The CMS archives were updated and properly filed in 1987, when the personalization fades. I can no longer go to the file to see what Dr. So-and-so looked like.

There should also be some kind of overall historical record of this organization. Every organization has a distinct culture which should be recorded. It should be a constant or, at least, frequent reminder of where the organization and its members have been, and a guide as to where they can go, based on their past accomplishments. It should be an assurance of factual history as well. Colorado Medical Society published a superb two-issue Centennial edition in 1971. I have used them as my touchstone for all the years I have been here. Robert Perkin and Harvey Sethman did an excellent job. Drs. Brad Murphy, Jim Delaney, Henry Toll, Jr., Wallace Livingston and all the other CMS Historians can be proud of their contributions to the cultural journal. Each member, past or present, can take a great pride in his/her organization and in being a part of its culture. And if you're not sure you have a file with your picture in it, send me the photo (5X7 preferred) and I'll be sure there is a permanent file in your name. Or I'll add the photo to your file.

We'll probably have to wait until 2071 for another "history". It won't be the same though; it'll probably be on a floppy disc or maybe a "read-only CD".

PRESIDENT'S LETTER



M. Ray Painter, MD
President, 1996-1997

Last month I noted that the game has just begun. You will recall my call to action, "O.K. we've got 'em right where we want 'em", referring to the opportunity that physicians have to partner with patients to regain control of the health care system. An opportunity that has resulted from the continued transformation of the health care system. This month I would like to lay out my game plan. This strategic preview serves to energize one of the most important players in the battle to preserve high quality patient care – you, the individual physician. It also highlights a few of the issues on which CMS will focus during the coming year.

December will feature an informative article on what could be considered a very negative topic – fraud and the physician. Most of us are guilty of fraud, as defined by the Health Care Financing Administration (HCFA). We do not properly document all of our services, nor do we pay attention to the very precise and exacting rules on coding and reimbursement. Yes, I know you are all aware of these issues. However, the new Kennedy-Kassebaum Bill, which goes into effect in January, adds a new dimension to the word "fraud". Known for its creation of portable health insurance, the bill specifies fraudulent physician actions, including providing a pattern of "medically unnecessary" services, upcoding, as well as certifying an undeserved home health service. Physician fraud and the effects of this new legislation will be discussed in detail.

The new year will ring in with a

special on information, and how using it correctly will be one of the most important skills that doctors will need in the future. New technological and qualitative data management techniques will be discussed, concentrating on how the medical society will find, organize and qualify the information you need to practice better medicine. In our daily roles as clinicians, administrators and business people we need to have the best information available to assist us in our many roles, including patient advocacy. This article will focus on what CMS is doing for you and your patients on the information front.

February will feature the efforts of the Collaboration Committee. My inaugural speech stressed the importance of bringing *all* of the different component and specialty societies of organized medicine in Colorado under one umbrella. The Collaboration Committee, created during the 1996 CMS Annual Meeting, will be comprised of members appointed by each of the major specialty societies. It will act as a forum to resolve the "split the pie" and "turf battle" issues that are currently destabilizing the house of medicine. The committee will address, negotiate and recommend specific solutions to contentious topics. Those recommendations will then be submitted to CMS. The Collaboration Committee will help unify all of the voices of medicine.

The Scope of Practice Task Forces and Work Groups also hold great promise in addressing the turf battles between the medical profession and alternative medicine. An

"We can and must partner with patients to address the problems of today, and help devise the health care system of tomorrow."

upcoming article will examine how the task force will utilize factual information to address these issues in an attempt to create positions that can be successfully supported by organized medicine. It is important to establish relationships with interested parties now, before legislative intervention occurs.

Articles on patient advocacy, featuring the work of CMS President-elect Dr. Gary VanderArk, will examine access and indigence issues. It is critical to reinforce our patient advocacy mission. **Ultimately, it is the patient who will refocus the direction of health care reform.** We must provide them with the organization and the tools to do so.

Last but not least, I will address the role of the physician in the health care system of the future. Developing an organized delivery system with quality, access and accountability to patients sounds like a daunting task. Don't let me kid you, it is. However, as leaders in health care, organized medicine stands in the best position to help solve many of the problems. We can and must partner with patients to address the problems of today, and help devise the health care system of tomorrow.

LEGAL UPDATE

Negligent diagnosis damages

In a landmark decision, the Colorado Court of Appeals entered an Order which affirmed, in part, a \$220,000 judgment against a physician who had been found liable for negligently diagnosing a malignant lump in the Plaintiff's breast as being benign resulting in a 92-day delay in detecting her breast cancer. After Cancer was correctly diagnosed, Plaintiff underwent a radical mastectomy and removal of her lymph nodes. Plaintiff conceded that the operation would have been necessary even if there had been no delay in the detection of the cancer. The operation and subsequent chemotherapy were successful and, as of the trial date four years later, Plaintiff was cancer free.

The principal issue at trial was the effect of the delay in the detection of

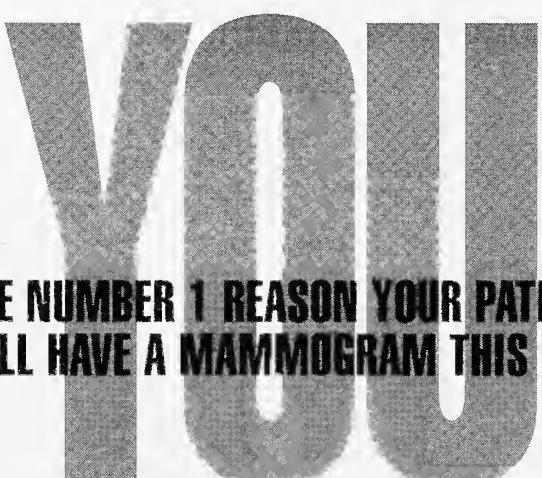
the cancer upon the risk that Plaintiff would experience a reoccurrence of cancer and also whether, as a result of the delay in diagnosis, she suffered a reasonable fear of increased risk of developing cancer in the future. The Court of Appeals agreed with the Defendant doctor that Plaintiff could not recover damages for an increased risk of cancer reoccurrence because she failed to prove to a reasonable medical probability that the future harm was more likely than not to occur. However, the Court found that a present fear induced by the possibility of contracting a disease constitutes an existing component of mental anguish and may be included in recoverable damages. The Court did agree with the Defendant's contention that a recovery for emotional distress, arising from fear of an increased

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risk of cancer reoccurrence, is laudable only if the fear is reasonable. The fact that delay in diagnosis increased the opportunity for the cancer to metastasize and caused a delay in the opportunity to cure the cancer were legitimate reasons for the Plaintiff to have an increased fear as the larger the tumor, the more cancer cells are present and, therefore, the greater the likelihood that more cells will develop a resistance to chemotherapy the longer they remain in the body.

For further information please contact:

A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
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AT PRESS TIME...

CMS Med Fax®
by Montgomery Little and McGrew, P.C.
legal counsel to the Colorado Medical Society

CMS to launch web page on January 1, 1997

The questions and the calls continue to flood in regarding when the Colorado Medical Society will officially launch its new Internet homepage. CMS leadership and staff are working hard to bring all of the necessary information and equipment on line by January 1, 1997. Barring any major setbacks, CMS will have a working presence on the web in the new year.

During the 1996 Presidential Planning Session in Breckenridge, leadership made the decision to augment the society's communication/information capabilities using the Internet. Notably, there was a strong desire for better communication between CMS members, leaders and staff. The upcoming web site was designed to address many of those issues.

The web page was created as a reinforcement tool for the society's physician and patient advocacy missions. It will feature four different sections: What's New; CMS Info; CMS for Physicians; and CMS for Patients. An exclusive members-only section will allow members to review specific society policies and projects. This section will also feature up-to-the-minute legislative briefs and information specific surveys.

CMS is relying entirely on in-house resources to design and implement the web page. The initial push for a CMS homepage was created by the CMS Committee on Medical Informatics and other leadership. Expert assistance from the University of Colorado Health Sciences Center also helped iron out some of the technical and qualitative design issues. The decision to not contract the CMS web page out to a private web page designer was made for both economic and security reasons. Dr. Lee Golter's Western Rockies Regional Health Information Network will function as the Internet service provider.

The web offers the opportunity to provide critical information about health care in Colorado to an ever-widening audience. Look for an in-depth feature article on the new CMS website in the December edition of *Colorado Medicine*. Please feel free to contact the CMS Communications Department at (303) 779-5455 or 1-800-654-5653 with any suggestions you might have. Or fill out the survey on page 366 in this issue and return it. CMS would like to thank all of you for all of your input and enthusiasm for this new project.

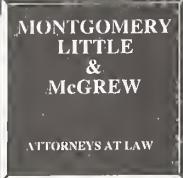
Domestic Violence Research Project

The Colorado Medical Society continues to work with local residency programs to replicate a Minnesota Medical Association study on physician detection of family violence. The purpose of this simple study is to ascertain whether physicians wearing buttons with an anti-abuse message ("Talk to me about family violence and abuse") have more conversations with their patients about violence than physicians not wearing such buttons. The Minnesota study found that wearing the buttons significantly increased conversations regarding family violence, and made physicians more consistent in talking about violence with patients. CMS will make

buttons available to members if similar results are found in Colorado. These buttons will act as a resource to help you intervene on behalf of your patients who are involved in domestic violence.

The internal medicine residency program at St. Joseph's Hospital has just completed a one month pilot study of the program. While work on fine-tuning the study protocols continues, the abstract has been expanded to include the general surgery, family practice and OB/GYN residency programs at the hospital. Other residency programs throughout Colorado are

(continued next page)



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Revised Antitrust Guidelines Issued by Department of Justice and FTC

In August the Justice Department and FTC released revised antitrust guidelines for the healthcare industry concerning how healthcare providers and hospitals can enter into joint ventures and other collaborative activities without violating antitrust laws. The revised and expanded guidelines are designed in part to clarify the antitrust principles applied by the Department and FTC when analyzing physician network joint ventures and multiprovider networks. They also signal an awareness by the Department and FTC of changes in the healthcare market and the need for flexibility when analyzing the different emerging arrangements.

According to the Justice Department, the guidelines reflect and promote the continued emergence of innovative healthcare arrangements to meet consumer demand for cost-effective, high-quality healthcare services. Physician network joint ventures that offer consumers significant efficiencies and are reasonably necessary to achieve them, will be reviewed under a flexible analysis rather than viewed as naked price-fixing agreements.

The nine statements issued (142 pages) build upon the set of similar statements issued in 1993 and revised in 1994. All outline antitrust principles applied in analyzing the legality of a variety of joint ventures and other activities by healthcare providers that may be procompetitive and cost-saving, and thus alleviate antitrust uncertainty in these areas. They also discuss seven new hypothetical examples of how the antitrust

laws apply to specific situations, including several addressing physician-hospital organizations, one of which relates to a rural market involving a large percentage of physicians that would receive favorable treatment under antitrust laws. Other matters addressed include:

- an example of a "messenger model" arrangement that explains how unintegrated networks can facilitate physician contracting with payors while avoiding unlawful price agreements;
- safety zones for networks of particular sizes that share substantial financial risk — 20% where exclusive and 90% where non-exclusive;
- additional examples of substantial financial risk sharing, emphasizing that a physician network joint venture can be procompetitive even if it does not come within a safety zone;
- safety zones, defining circumstances in which the Department and FTC will not challenge such conduct, emphasizing that conduct falling outside the safety zones may be lawful; and
- a commitment to an expedited procedure to respond, generally within 90 days, to parties seeking additional guidance on proposed healthcare joint ventures and other activities.

"Statements of Antitrust Enforcement Policy in Health Care" is available from the U.S. Department of Justice. I will attempt to make a copy available for those of you who want to look more closely at the revised guidelines.

(Domestic violence study cont. from previous page)

considering participation in the study as well. Results will be published in *Colorado Medicine*.

This study is part of the ongoing CMS efforts to provide tools to physicians to assist them in responding more effectively to patients who are involved in domestic violence. For more information or resource materials, please call Ellen Stein at the Colorado Medical Society at 930-0414 or 1-800-654-5653.

Don't forget!

It is time to order copies of the AMA's 1997 Current Protocol Terminology (CPT) and the International Classification of Diseases (ICD-9-CM) reports. Medicare requires the use of the new codes on January 1, 1997. Use the codes or face denial or delayed payment. Please call Marilyn Rissmiller in the CMS Health Care Financing Department at (303) 779-5455 or 1-800-654-5653 for more information.

Acute stroke network formed to provide better care

Health care professionals in the Denver area have teamed up to promote the rapid adoption of safe and effective therapies for acute stroke. The Colorado Acute Stroke Network has been established through the combined efforts of the Rocky Mountain Stroke Association, the National Stroke Association and the American Heart Association.

More than 5,400 strokes occur in Colorado each year, causing increased pressure on the public health system, as well as tragic human suffering. Historically stroke has been viewed as untreatable. However new therapies and drugs have shown great promise. While clinical trials continue, there is still a considerable amount of circumspection with regard to potentially dangerous new treatments.

The Colorado Acute Stroke Network (CASN) was formed to:

- promote rapid, safe, and effective treatment of stroke in Colorado;
- monitor outcomes of those so treated, in order to continually improve stroke care.

Initially the network has worked to disseminate information about stroke, stroke prevention, and stroke treatment. That information is currently being used to create guidelines for acute stroke treatment and for informed consent protocols for acute stroke treatment. Other objectives include:

- establishing a 24-hour hot line for doctors with questions about new acute stroke therapies;
- developing a state wide stroke treatment/outcome data base; and
- encouraging local research in acute stroke treatment.

The network includes physicians and other health professionals and organization with expertise in stroke, along with representatives from Colorado hospitals, the National Stroke Association and the American Heart Association. The Rocky Mountain Stroke Association is the network's sponsoring agency.

For more information about the Colorado Acute Stroke Network please call Mellodee Lowther at (303) 782-5831.

Managed care report finds HMO profits down, enrollment up

Allan Baumgarten has released the third annual report analyzing key trends in Colorado health care. *Colorado Managed Care Review 1996* compares HMOs and examines the impact that purchasers and providers are having on the market. The report found that HMO profitability was down, despite the fact that enrollment had increased. It also found that physicians are implementing new strategies to recapture their influence on the market.

Other conclusions include:

- Flat increases in premium revenues lowered HMO margins. Colorado HMOs reported average profit margins of 2.7 percent, down from 4.5 percent in 1994 and 5.1 percent in 1993.
- 30 percent of the state's population, nearly 1.1 million people, are now enrolled in HMOs. Enrollment increased by 11 percent in the first half of 1996.
- Hospital consolidation has been spurred by HMO growth. However, little progress has been made in taking surplus capacity out of the system. Columbia and Centura have emerged as the two largest hospital systems.
- Doctors are taking innovative steps to ensure their access to patients. Examples include increased interest in shared-equity group practice arrangements and management service organizations.
- Employer coalitions and government purchasers are working together to provide better information to consumers. In 1997, state agencies and two employer coalitions hope to jointly collect health plan and enrollee satisfaction data.

Colorado Managed Care Report 1996 also analyzes issues which the CMS House of Delegates has specifically addressed. Uniform disclosure of HMO income and expense categories (see RES-34-P, AM '94), including medical loss reports, are reviewed.

The report can be purchased directly from Mr. Baumgarten for \$60 by calling (612) 935-9121. If enough interest is expressed by members, CMS may procure a discounted price for the report. Call Edie Register at (303) 779-5455 or 1-800-654-5653 for details.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
November 7-8, 1996
Englewood, Colorado
(303) 397-7876

HIV Clinical Training Program

Col. AIDS Educ. & Training Center and UCHSC
November 13-15, 1996
Denver, Colorado
(303) 355-1305

International Meniere's Disease Research Institute

8th Annual Seminar and Workshops: Diagnostic and Rehabilitative Aspects of Dizziness and Balance Disorders
December 4-7, 1996
Denver, Colorado
Contact: Jane Wells, (303) 788-4235

Colorado Hospital Association

Accreditation Standards for Hospital-Based Ambulatory Care Services
December 5-6, 1996
Denver, Colorado
(303) 758-1630

MGMA/CRAHCA

Physician Services Practice Analysis Software Hands-on Training and Report Analysis Workshop
December 5-6, 1996
Englewood, Colorado
(303) 397-7876

University of Colorado's CME in the Rockies

5th Update on Infectious Disease:
Bugs and Drugs in the 90's
December 6-7, 1996
Denver, Colorado
(303) 372-9050 or 1-800-8820-9153

American College of Cardiology

The 28th Annual Cardiovascular Conf. at Snowmass
January 13-17, 1997
Snowmass, Colorado
CME Credit: 22 Category 1 AMA
1-800-253-4636 ext. 695

Disease Management Congress

Implementation and Outcomes Measurement
January 14-17, 1996
San Francisco, California
800-446-6422

HIV Clinical Training Program

Col. AIDS Education and Training Cntr. and UCHSC
January 15-17, 1997
Denver, Colorado
(303) 355-1305

American Diabetes Association & Colorado Society of Endocrinology

33rd Annual Colorado Diabetes/Endocrinology Inst.
January 18-23, 1997
Aspen-Snowmass, Colorado
1-800-782-2873

American College of Cardiology

Cardiovascular Conference at Snowbird
February 12-14, 1997
Snowbird, UT
CME Credit: 19 Category 1 AMA
1-800-253-4636 ext. 695

Medical Education Resources

Managing Respiratory Diseases
February 14-16, 1997
Breckenridge, CO
1-800-421-3756

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference
February 23-28, 1997
Keystone Lodge & Resort, Colorado
CME Credits: 39 hours AOA Category 1-A CME crdt
Patricia Ellis (303) 322-1752 or 800-527-4578

EXECUTIVE DIRECTOR'S UPDATE



Sandra L. Maloney
Executive Director
Colorado Medical Society



We at CMS and Copic were all suddenly shocked in early October to hear that Dr. Rich Quinn (Richert E. Quinn, MD, Copic Risk Management) was in intensive care at Greeley Medical Center suffering from meningitis.

It was pretty common knowledge that Rich was working and traveling too hard and had not been feeling well recently. It certainly did not occur to anyone that this sort of catastrophic illness could suddenly swoop down on one of our own.

Because of all of his close friends and associates at Copic and CMS, we have been able to monitor Rich's condition pretty closely for these ensuing weeks, and let me say it was a hairy experience. As we get to the end of the month the reports of his progress are good; he's out of ICU; he called in to the office to say he wouldn't be in for a while because he had to take care of some other things. I was allowed to talk briefly with him on the phone, and he said "Maloney! Don't be making fun of me!" Even though he kind of faded in and out of lucidity (because of the effects of the disease and the medication), it all sounded like Rich, and that was good!

The medical community, and particularly physicians, is a pretty close-knit group, so the word got around quickly. That's to be expected in the case of a loved one. What's still astonishing to me is the fact that one of "us" can be stricken so easily, can be plucked out of our midst, our lives threatened, with no warning and no very good reason. We need a "wake-up" call every once in a while just to be reminded

that we can't take much of anything for granted. We also need to remind ourselves how thankful we should be that so many of these threats have happy outcomes and how much time on earth we have been able to spend in good health and freely in pursuit of personal happiness. There's not a one of us who doesn't bear some kind of cross for what has been thrust upon us, or carry a torch for what might have been; yet we function.... and we deal with it, whatever it is. There are many others who are stricken and who simply can't fight back.

I know. . . you know all that!

So here we are, about to swing wide the door on another holiday season when we are supposed to celebrate tradition, give thanks and reach out bearing gifts and good wishes for our fellow humans. Just don't forget, as we pass through that door to begin our observances, how close we all are to the line, how it can happen to any of us, how thankful we each should be for our good fortune, and how each of you still represent the finest profession of all, the healing profession.

We will be very thankful for Rich Quinn's recovery, for the remarkable skill and service of those physicians who treated him, for his family being there, rallying at his bedside, for his many, many good friends who have expressed their concerns and caring about him.

I hope this will be a constant reminder to me of just how fragile human life truly is.

And I am thankful.

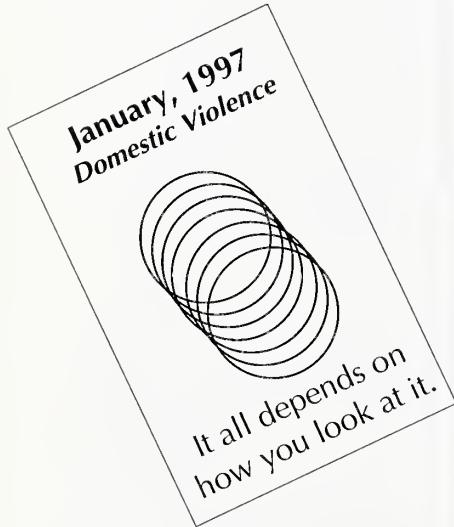
"How fragile human life truly is."



Domestic violence: Medicine's Role in Stopping the Violence

by Ellen Stein, Director
CMS Department of Health Care Policy

It all depends on how you look at it.



The National Coalition Against Domestic Violence (NCADV) fact sheet states:

- **Every 15 seconds** a woman is battered in this country;
- Battering is the **single largest cause of injury** to women in the United States - over mugging, automobile accidents and rape;
- **Every year more than 1 million women seek medical treatment for injuries inflicted** by husbands, ex-husbands or boyfriends;
- In homes where domestic violence occurs, **children are abused at a rate of 1,500% higher** than the national average.

The results of domestic violence, physical, emotional and sexual assault, are seen by physicians on a regular basis. Physicians have a very crucial role to play in what needs to be a community-wide approach to ending this violence. You can't fix it by yourself, but your role is to:

1. **See it** - Don't just treat the resulting injuries without recognizing the domestic violence. Ask questions. Research indicates that patients want their doctors to ask about violence and feel their doctors could be helpful. You are often in the unique position of being the first non-family members to whom an abused person turns for help.
2. **Treat the injuries** - examine the patient in private, being firm about excluding the possible abuser from the exam room. Use caution in administering or prescribing tranquilizers or sleeping pills, especially if the patient is returning home and the possible abuser is still there.
3. **Refer your patients** to sources of assistance who are skilled in work-

ing with domestic violence.

4. **Report** injuries resulting from domestic violence to the police.

Over the course of the next year, the Colorado Medical Society will be providing you with information and resources to assist you in these efforts. Each month, in **Colorado Medicine**, we will print a calendar for the following month. You will be able to tear this calendar out, slip it in your pocket and use it to keep track of meetings and other important events. On the back of the calendar each month will be resource information to assist you in working with your patients who are involved in domestic violence. We will cover the domestic violence reporting law, guidelines for reporting to law enforcement, more detailed information on your role in intervening in domestic violence, how to identify victims of domestic violence, how to ask them questions and discuss their situation with them, and related issues such as sexual assault, the impact of domestic violence on children, and elder abuse. Each month we will identify for you additional resources you can use or provide to your patients.

We want to help you keep your role manageable. Most importantly, we want Colorado physicians to truly be patient advocates: **Don't let your patients suffer in silence.**

For additional information or resource materials, please contact Ellen Stein at the CMS offices, 779-5455 or 1-800-654-5653 or E-mail: Ellen_Stein@cms.org. We have posters, physician guidelines and resource cards available for use in your offices.

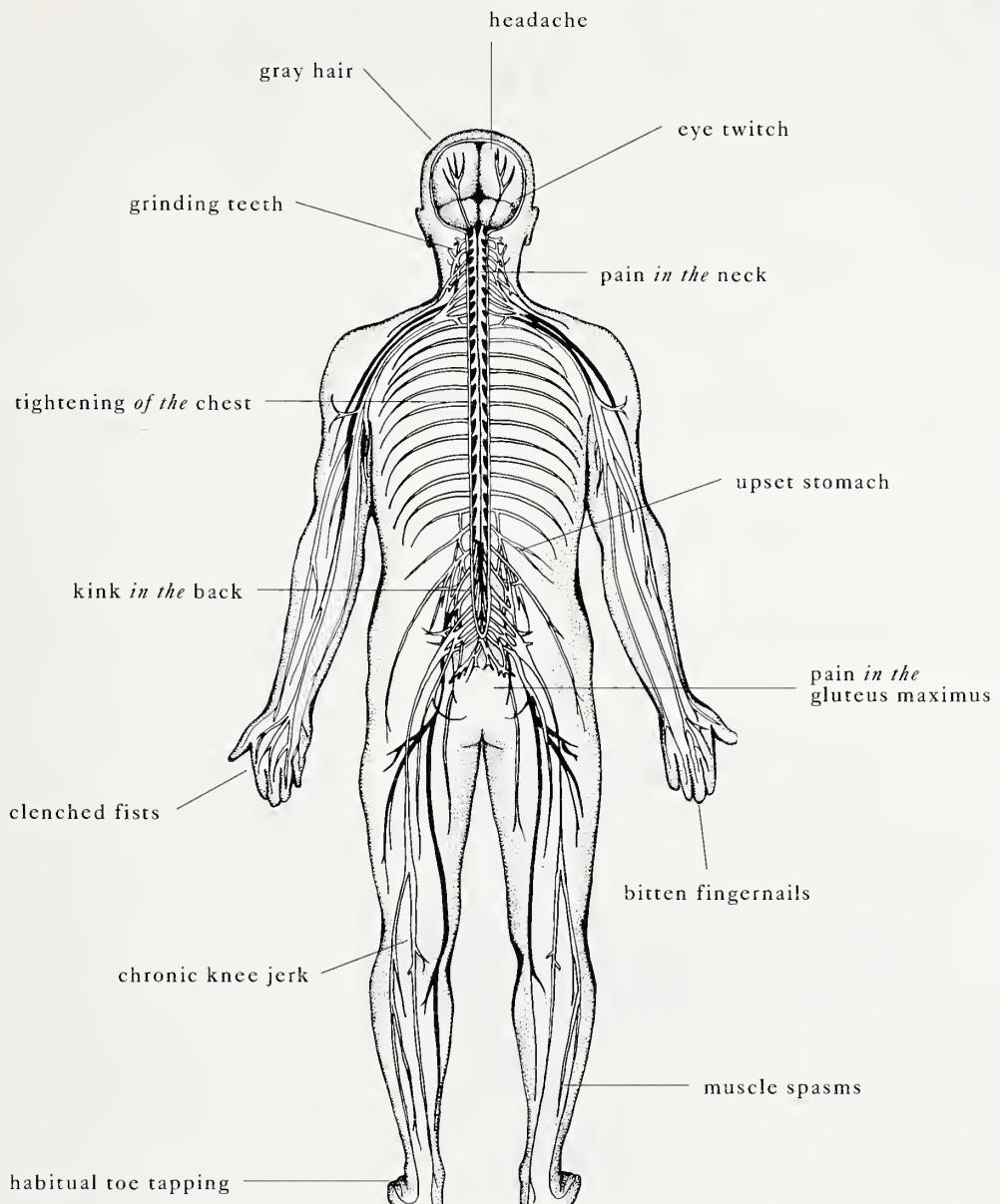


Figure 23

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What's in an acronym?

The acronym has become the fast food of language, and organized medicine is no exception. Here is a list of commonly used Colorado Medical Society acronyms. Hopefully it will appease some of the indigestion associated with the speed of medical society communication today.

CMS Acronym Listing

AA	Aurora-Adams Medical Society	CEJA	Council on Ethical and Judicial Affairs	HCP&F	Health Care Policy & Financing Department
ACEP	American College of Emergency Physicians	CFMC	Colorado Foundation for Medical Care	HEWI	Health, Environment, Welfare & Institutions Cmte (Legislative)
ACP	American College of Physicians	CHMOA	Colorado Health Maintenance Organization Assoc.	HHS	Health and Human Services
ACS	American College of Surgeons	CMS	Colorado Medical Society	HOD	House of Delegates
AG	Attorney General	Cmte	Committee	HSR	Health System Reform
AM	Annual Meeting	COL	Council on Legislation	IM	Interim Meeting
AMA	American Medical Association	COMPAC	Colorado Medical Political Action Committee	JBC	Joint Budget Committee (Legislative)
App	Appropriations Committee (Legislature)	COPS	Congress of Physician Specialties	Jud	Judiciary Committee (Legislative)
ASIM	American Society of Internal Medicine	COS	College of Orthopedic Surgeons	MCTF	Managed Care Task Force
BA	Business Affairs Committee (Legislature)	CPEA	Committee on Professional Education and Accreditation	MEG	Medical Executive Group
BME	Board of Medical Examiners	CPEP	Colorado Personalized Education Program for Physicians	MGMA	Medical Group Managers Association
BOD	Board of Directors	CPHP	Colorado Physician Health Program	MSC	Moved, seconded, carried (used in minutes)
BON	Board of Nursing	CPN	Colorado Physicians Network	MSC	Medical Student Component
CAC	Carrier Advisory Committee	CROP	Colorado Rural Outreach Program	NFIB	National Federation Independent Business
CACI	Colorado Association of Commerce and Industry	C.R.S.	Colorado Revised Statutes	OSC	Organizational Study Committee
CAFP	Colorado Academy of Family Physicians	CSHP	Comprehensive School Health Program	PCMA	Professional Convention Management Association
CCHK	Colorado Connection of Health Kids	CSIM	Colorado Society of Internal Medicine	PHIC	Physician Health Issues Committee
CCI	Correct Coding Initiative	CSOM	Colorado Society of Osteopathic Medicine	RBRVS	Resource Based Relative Value System
CCV	Clear Creek Valley Medical Society	DMS	Denver Medical Society	RMSC	Rocky Mountain State Conference
CDHE	Colorado Department of Health and Environment	DOI	Division of Insurance	RPS	Resident Physician Section
		DORA	Department of Regulatory Agencies	SOPTF	Scope of Practice Task Force
		DOWC	Division of Workers' Compensation	TF	Task Force
		DV	Domestic Violence	UCHSC	University of Colorado Health Sciences Center
		EPCMS	El Paso County Medical Society	UCSM	University of Colorado School of Medicine
		ERF	Education and Research Foundation	WCPIC	Workers' Compensation/ Personal Injury Committee
		HAC	Health Affairs Council	WIM	Women in Medicine
		HCFA	Health Care Financing Administration		

Your last patient yesterday has had his first heart attack

...and is headed for his second. His wife called you today in tears, saying "He's just not his old self. He's edgy, irritable, and since his heart attack, all we ever do is fight."

You've already counseled him to take some time off, take things easier, and lighten up on the competition, but he can't seem to stop.

Would you like some help getting through to him? In my 25 years in this field, I've teamed up with many physicians to help patients like this fella.

David Daniels, M.D., Stanford, says, "Dr. Smith is a mature, thoughtful, and compassionate psychologist with integrity, dedication, and a broad knowledge of psychology."

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Michael Smith, Ph.D.

- Private practice, 1983 to present
- Faculty, The Naropa Institute, 1996
- Faculty, Institute of Transpersonal Psychology, 1983-1996
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Medicare's Correct Coding Initiative

by Marilyn Rissmiller,
CMS Health Care Financing Department

Part one of a two part series

Medicare's Correct Coding Initiative (CCI) continues to generate questions and frustration for physicians and their billing staff. According to the Medicare Carrier for Colorado, calls questioning CCI denials are one of the top reasons physicians' staff contact them, second only to calls checking claims status.

Background

Organized medicine had asked for a delay in implementation of the CCI. The delay would have allowed time to review the listing for accuracy and educate doctors on what constitutes "correct coding". Despite significant objections from the AMA and specialty societies, the Medicare program implemented the first phase of the Correct Coding Initiative on January 1, 1996 in response to pressure from key members of Congress. (The purpose of the CCI is to reduce program expenditures by detecting "inappropriate" coding on Medicare claims and denying payment for them.)

Coding or "rebundling" edits are not new for the Medicare program. They had their humble beginnings in 1991 with the implementation of the first 68 procedure code combinations. However, there are some new aspects to this year's rebundling, not the least of which are:

- **Size** – In 1991 there were only 68 procedure code combinations. In 1996 approximately 83,000 procedure code combinations were introduced.
- **Publication** – From 1991 until 1995, the Medicare Carriers published rebundling lists for physicians. With the implementa-

tion of the CCI, the Health Care Financing Administration (HCFA) told carriers they could *not* publish the CCI information. (Physicians must purchase the CCI manual from a government printing agency, NTIS.)

What is it?

According to HCFA, the code edits were developed based on a review of: CPT descriptions, CPT coding instructions and guidelines, as well as, local Medicare carrier and national edits, and Medicare billing history. The correct coding policies (reasons for denial) are listed below:

- CPT Procedure Coding Definition
- CPT Coding Manual Instruction/ Guideline
- Mutually Exclusive Code Pairs
- Sequential Procedures
- Separate Procedures
- Most Extensive Procedures
- "With"/"Without" Services
- Sex Designation
- Standards of Medical Practice

What it means to you?

To have a better understanding of how the CCI impacts your office billing you need to have a copy of the coding combinations that pertain to your practice. You can obtain this information by purchasing a copy of the CCI manual (also available by chapter), or one of the many commercial reference books available (see PRS ad on next page). Be sure that whatever publication you purchase includes updates. (Phase II has been released, and Phase III is in the works now.)

What to do if you disagree with a combination?

The AMA and national specialty

societies are working together to provide formal input to HCFA through the Correct Coding Policy Committee. If you disagree with a CCI edit, please contact the CMS Health Care Finance Department or write your specialty society and give them your rationale.

Questions

If you are not satisfied with the explanation you received from the Medicare Carrier on a particular case/coding combination; or if you would like to know more about ordering the CCI information, please contact Marilyn Rissmiller at CMS in the Health Care Financing Department, (303) 779-5455 ext. 2428 or 1-800-654-5653.

The complete correct coding policy definitions and examples will be published in the December edition of Colorado Medicine, along with information on the use of the Medicare Modifier (GB) indicating a distinct procedural service.

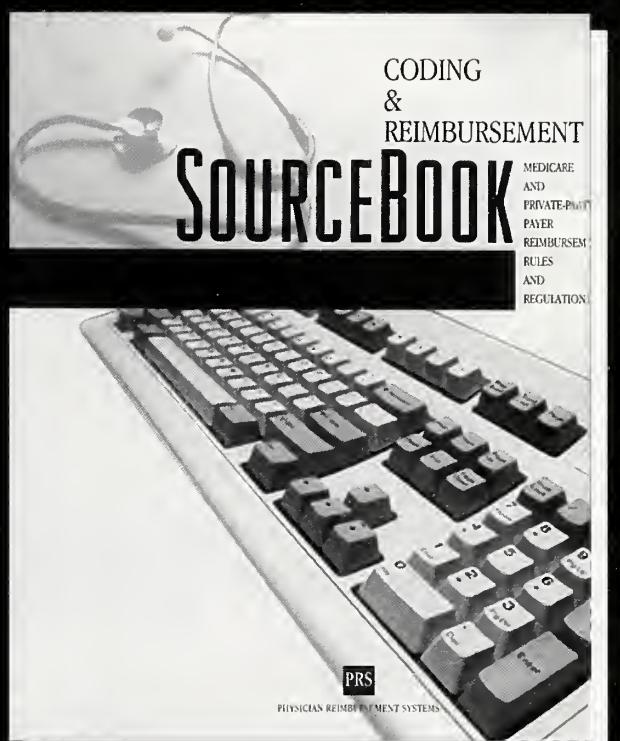
Confused about coding?

The *Coding and Reimbursement SourceBook* is your solution to coding confusion. There are 26 different specialty-specific books available. Each *SourceBook* is loaded with useful data including:

- HCFA's Correct Coding Initiative
- Information on coding changes
- Coding tips and warnings
- Advice for Medicare and private payers
- State specific information

Updated three times a year, the *SourceBook* is available to CMS members for the discounted price of \$132. Compare this discount to the non-member rate of \$184, plus \$15 shipping and handling!

For more information, call Marilyn Rissmiller in the CMS Health Care Finance Department at 779-5455 or 1-800-654-5653.



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Heard on the hill: Upcoming legislation on Medicaid and intractable pain

by Suzanne Hamilton,
CMS Government Relations Department

"This legislation requires the state to place 75% of Colorado Medicaid recipients into managed care by July 1, 2000."

The legislature certainly has been busy, despite the fact that it will not be in session until January 8, 1997. Interim committees and task forces have been meeting throughout the summer and fall months. Two of these have been studying issues of great importance to medicine - Medicaid and intractable pain. Here is what they have come up with so far:

Medicaid

The Statewide Medicaid Interim Committee has received approval to proceed with a Medicaid Reform bill which will create a statewide managed care system, subject to federal waivers. This legislation requires the state to place 75 percent of Colorado Medicaid recipients into managed care by July 1, 2000. The bill also identifies the types of data that providers must supply to the state, and requires the state to compile data on health outcomes.

Other specific proposals in the Medicaid Reform Bill include:

- requiring the state to evaluate the cost-efficiency of the state's managed care program;
- authorizing the state to maintain the Primary Care Physicians (PCP) Program;
- developing a program of financial incentives to maintain superior quality of service;
- requiring the state to hire independent contractors to administer up to 20% of the statewide managed care program;
- submitting a list of recommendations to the legislature for the implementation of a consumer

certificate choice program (much like a voucher system).

Intractable pain

The Intractable Pain Task Force was charged with studying and providing recommendations on appropriate policies or legislation relating to the management of intractable pain. As a result of recent testimony, the Task Force concluded that:

- many patients in Colorado needlessly suffer from inappropriate pain levels;
- patients are entitled to a reasonable expectation of effective and safe pain relief;
- the "culture" of medicine encourages physicians to follow a "disease treatment" model that places insufficient emphasis on pain treatment;
- a greater emphasis on pain management in educational programs for medical professionals would be beneficial;
- improved methods of tracking health care costs related to the treatment of intractable pain would be useful in evaluating the economic costs and benefits of treatment alternatives;
- health care professionals have a moral duty to adequately manage patient pain;
- a "hospice model", whereby the state of pain of patients is communicated, assessed, documented, and appropriately managed, should be encouraged as routine practice in all Colorado health care facilities; and

(Continued next page)

- interdisciplinary approaches to the management of patient pain are effective and recommended.

In response to these findings, the Task Force has recommended and received approval to pursue four pieces of legislation. The first bill will address the scope of insurance provisions regarding the treatment of pain through health plan disclosure. If the plan provides coverage for the treatment of intractable pain, the new law will require access to either a physician board-certified in pain management or referral to a pain management specialists or pain clinic. If the plan is silent on the coverage of intractable pain, the plan shall be presumed to offer coverage.

The second bill authorizes pharmacists to dispense prescriptions in emergency situations involving hospice patients without written authorization from a physician. This practice must be consistent with federal law on emergency prescriptions.

The third bill clarifies the sanctions that physicians may face when prescribing medication for intractable pain. Physicians who prescribe controlled substances **solely** for the relief of intractable pain will **not** be subject to disciplinary actions by the BME.

The final piece of legislation will be introduced in the form of a resolution urging medical malpractice insurers to grant premium discounts or other incentives to physicians who obtain continuing medical education (CME) in the assessment and treatment of pain.

The CMS Government Relations Department is closely watching these and other developments. The outcome of the November elections may dramatically affect the composition of the Colorado Legislature. Look for election results and upcoming hot issues in the December edition of *Colorado Medicine*. If you have any questions please call (303) 779-5455 or 1-800-654-5653.

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For more details, call **(800) 864-4388**. In Denver, **753-0440**.

Colorado Medical Society



Time to move: Technology's impact on medicine

by Chet P. Seward,
CMS Communications

"There are only so many ways to look at a cottage."

Medicine is a cottage industry. An industry that uses outdated technology, old techniques, and relies in some ways more on professional ingenuity than on innovation. Patients are frustrated. Perhaps the only reason why the profession is still held with such high regard is due to the fact that physicians instill a humanistic touch to the technical aspects of science. That high regard may falter because certain myths and methods continue. For many patients, doctors are still "gods in white coats" who tell them to take two aspirin and call in the morning. Medicine is stuck in the rut of old ways.

Fortunately times are changing. New technology, specifically information and computer based applications, has begun to affect the way health care is delivered. Patients are taking a more active role in their health care by demanding more information. Many physicians are attempting to fulfill those needs, but the change is often difficult.

"How am I supposed to keep up with all the changes in medicine, while simultaneously mastering the nuances of new technologies which are 'supposed' to help me provide better care?" you ask. The answer is that you **can't**. Practicing medicine today is hard enough. No one can realistically expect you to become a computer guru/communications specialist in the small amount of free time that you have. Perhaps the "cottage" behavior continues because questions like the one above never even get asked.

CMS President M. Ray Painter, MD, has said that in the future those

that have the data have the gold. Like it or not, health care providers must expand the channels of communication. Those that do will succeed, those that don't will fail. Keynote speaker Leanne Kaiser Carlson went even further at the 1996 CMS Annual Meeting by stating that physicians that do not utilize modern information technologies in the future will be held liable for medical malpractice.

Both patients and managed care are demanding better information, and the stark reality is that many physicians are caught in the rut of old behaviors. They refuse to ask for assistance from experts in the communications and information technologies field. Maybe it is because they are afraid of computers. Maybe they don't know what they want or need. Maybe it is because they are too busy trying to care for their patients to even think about changing the way they provide that care. The crux is that physicians must seek help from information/computer experts because most doctors can only be experts in medicine. The profession continues to change and new technology is the key to that change. Medical informatics has the potential to transform the practice of medicine from a cottage industry to a more rigorous, evidence-based delivery system by collecting, analyzing and presenting new knowledge.

Making the move may appear daunting, but it can be done. First and foremost, talk to your colleagues about how they made the transition.

(Continued next page)

Here are a few more steps to consider:

- **Identify** your organization's needs. A needs assessment is critical because every physician's practice is different. The technology and the experts are available to help as long as you have determined what you need. Without an assessment, you may fall prey to vendors with a laundry list of applications that may be irrelevant to your practice setting.
- **Understand** the impact of the technological conversion. Bottom line, any changes you make will be a cultural change for both you and your staff. Try to anticipate problems and be patient when things don't go as planned or people are reluctant to cooperate.
- **Have a plan.** Any foray into new technology will be expensive. To make the transition as comfortable and economical as possible, know what your objectives are as well as

the time line you have planned to meet them.

- **CMS can help** you with the move. Please take a moment to fill out the survey on the next page. Results will assist staff in pinpointing areas where future membership services can benefit you the most.

There is a lot of talk these days about new vision, empowerment and paradigm shifts. Despite the jargon, there are only so many ways to look at a cottage. In the end it is still just a quaint little cabin. It is time for medicine to move out of the cottage of isolation and move into the technologically advanced home that can live up to the provider and patient needs of the twenty-first century. A home where patient care has never been better because information technology helps physicians do what they do best — practice medicine.

Turn page for survey 

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and **THE** scorecard is
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Survey on Medical Informatics

The Colorado Medical Society is constantly striving to provide you with the most up-to-date information on how you can make your practice more efficient and enjoyable. Recent advances in technology have opened new avenues of communication for the profession of medicine, and CMS is exploring all of them. The upcoming CMS web page is just one of the features that will assist you in obtaining current medical information, the newest practice management techniques, and the latest news on what CMS is doing for you. As the exploration of current issues and work on the web page progress, the need for membership input has grown. We need to hear from you!

**Please answer the following questions and return this survey to the CMS Communications Department,
Attn: Chet Seward, P.O. Box 17550, Denver, CO 80217-0550. Or fax it to us at (303) 771-8657.**

1. Would you like to know more about medical informatics and electronic data interchange?

Yes No

2. Do you use the Internet?

Yes No

If yes, what on-line services do you use most:

E-Mail News and education resources Other (please specify) _____

3. Is your office computerized?

Yes No

If yes, which services are automated:

Administrative (billing, scheduling, etc.)

Clinical (please specify) _____

Electronic Patient Record

Other (please specify) _____

4) If your answer to question number three was no, please elaborate why not:

5) What are your concerns about electronic data interchange?

6) What services would you like to see on the CMS web page?

7) Would you be interested in attending a brief, educational seminar on medical informatics which would specifically target questions you may have about how computer/information systems can benefit your practice?

Yes No

8) If your answer to question number seven was yes, please list those questions.

Thank you for your cooperation. Your input is valuable.

Your Name: _____

Address: _____

Phone Number: _____ **E-mail address:** _____

COLORADO MEDICAL SOCIETY ALLIANCE



*Stella Shanks, President
Colorado Medical Society Alliance*



What happened to the Auxiliary?

In 1993, the name Auxiliary was changed to Alliance to incorporate the growing numbers of male spouses. Physicians' spouses dedicated to the health of Colorado is still our mission.

Membership in the medical alliance means that we are part of a federation of medical alliances sanctioned by the American Medical Association (AMA).

The federation exists on three levels:

National – founded in 1922 with the concept of ensuring quality health care to all, through a federation of concerned, active spouses, the AMA Alliance provides program direction through campaigns such as SAVE. National also provides educational seminars and leadership training programs. Members receive the AMA Alliance Today magazine, and have access to

brochures and all published materials.

State – acting as a conduit, bringing information from the national to the county level, the state alliance serves as a coordinator for the county alliance programs, and provides assistance and direction.

County – implementing community service and health education programs based on the needs of the community, the county organization provides a support system for physicians and their families through service and fellowship.

What makes the CMS Alliance unique among volunteer organizations? Membership in the Alliance:

- makes you part of an organization that is one hundred percent dedicated to supporting the medical profession;
- provides a way to "give back" to

your community in projects which promote good health and safety;

- provides a means for you to stop America's violence mainly in areas of domestic violence;
- provides an outlet for political action at a time when the practice of medicine is threatened;
- helps you deal with challenges that are only understood and shared by other medical family members;
- provides you with personal and professional growth through leadership opportunities and education.

The Alliance has been referred to as the *heart* of the medical family. I would like each of you to encourage your spouse to join our organization, and keep the *heart* of your family strong. Please fill out the form below and join the CMS Alliance today.



YES, I want to join the Colorado Medical Society Alliance. Enclosed please find my information and a dues check.

Name _____

Address _____

City _____ ZIP _____

County _____

Dues: \$65 (payable to CMSA) county, state, national dues. Mail to Memebership Chair:
Patti Brown, 6865 W. Princeton Ave., Denver, CO 80235

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— William Gonda, MD, San Francisco

“This program makes it easy for me to routinely discuss firearm safety.”

— Marilyn Bull, MD, Indianapolis

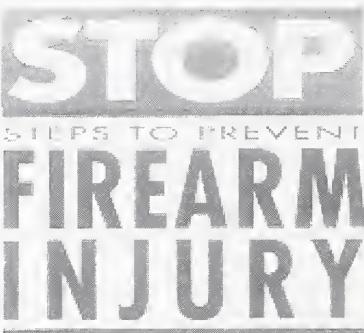
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— Christopher B. Houts, MD, FAAP, Phoenix

“The brochures are the perfect starting point for talking with parents.”

— Michael Clemmens, MD, Annapolis

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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



A Little Learning

A little learning is a dangerous thing;
Drink deep, or taste not the Pierian spring;
There shallow draughts intoxicate the brain,
And drinking largely sobers us again.

Alexander Pope, An Essay on Criticism (1711)

In recent weeks, a number of you have received information on behalf of other carriers telling you how much you can save "simply" by placing your professional liability insurance with them. As physicians, you know better than most people that "simple" things rarely are. These solicitations present an extreme and dangerous oversimplification of the myriad factors involved in choosing a professional liability carrier. When you are called on to make a diagnosis, you naturally want as much information as possible. There's a wealth of information available to help you decide where to place your professional liability insurance... but based on recent experience, you're not likely to get it from these solicitations.

You can get it from Copic. Of course we have an interest in retaining your business. But more than that, we want your professional liability insurance decision to be based on a full understanding of this complex arena. Knowing just a little — like how much you can save — can jeopardize not only your financial stability but your professional future as well. Here are some of the most impor-

tant issues you should keep in mind as you evaluate these various solicitations.

Who is offering the coverage?

How can you evaluate a carrier's history and financial soundness when you can't even find out who they are? Is it wise to rely on someone else's assessment when it's your future on the line? Are their so-called discounts actuarially justified, or are they just buying business that they won't be able to cover later? Are these the same carriers that abandoned you and your colleagues in the 1980s? (If you are new to the state, ask some long-time Colorado physicians about the time when Hartford and Phico left the state and about the subsequent class action lawsuit the physicians filed against Phico.) Will you have to call an out-of-state number in another time zone to obtain customer service and claims management? Will this company work in the Colorado legislature to safeguard tort reform? (And where were they during the tort reform struggle?)

Are they sacrificing accuracy for impact?

One of the solicitations sent to a Copic Board member attempted to make an issue of the distributions Copic has paid to

policyholders. The distributions are inaccurately characterized therein as "dividends." As you know, dividends are payments to stockholders from the company's profits. Since Copic has from its inception operated its professional liability insurance business on a not-for-profit basis, we have always returned excess premium to our policyholders and we are pledged to continue in this manner. Additionally, true dividends would have tax implications for physicians, while distributions applied as credit against premiums do not.

The solicitation also quoted statements Copic has made over the past year regarding the likelihood of future distributions, intimating that something is wrong because Copic "can't guarantee" that they'll be available. What they don't tell you is that, because of their very nature, no one can guarantee distributions. Distributions are not, as characterized in the solicitation, simply a refund of an "overpayment of premium in the past." Every year, Copic bases its premiums on rigorous actuarial projections, with no "pad" built in for

(Continued on following page)

profit. While we are always pleased when favorable loss developments and investment earnings permit us to pay distributions, we refuse to jeopardize our integrity and promise something we could not deliver. Therefore, we declare distributions retrospectively only after we can be certain that the funds are not required to cover losses. For 1997, our distribution will amount to \$6.0 million, bringing the total returned to policyholders since 1990 to \$46.4 million. Maybe that's old-fashioned... to us, it's the honest way to do business and fulfill the mission with which Colorado physicians have charged us. (For more information on distributions, see "If Copic can pay distributions, why can't they

reduce premiums?" in last month's Colorado Medicine, as well as your Notice of 1997 Rates and Classes from Copic.)

Are they telling you the whole story?

In the solicitation our Board member received, the unidentified carrier for "Program Two" is described as having "more than 6,000 physicians insured." What it didn't say is that this figure represents their insured base nationwide (not just in Colorado), and that the majority of those 6,000 insureds practice in other states.

In the same solicitation, this carrier is characterized as superior to Copic because it insures only physicians and hasn't branched into covering hospitals and managed care organizations. What it didn't say is that the furious pace of vertical integration in the healthcare delivery system is reshaping the professional liability insurance market just as rapidly, and that companies that

don't adapt and diversify as Copic has will quickly perish, leaving their policyholders adrift. Interestingly, policyholder requests were the impetus behind our entrance into these product lines — our policyholders wanted a Copic that would insure both them and their hospital employers. Ask yourself whether these other carriers are actively working on your behalf in Colorado to create solutions for you in the midst of these types of changes — solutions like free coverage for retired physician volunteers, streamlined credentials verification, and non-intrusive physician site visits.

It is my sincere hope that this article has been a "deep drink" of knowledge for you. I am convinced that the more you learn about professional liability insurance and the companies offering it, the more you'll agree that Copic remains the right choice. Thank you.

Colorado Physician Network, Inc.



by David C. Martz, M.D., President
Colorado Physician Network (CPN)

On September 25, 1996 your new "membership-elected" CPN Board of Directors met for the first time and tackled an immense agenda, covering almost 20 items of action, policy, information and strategizing spanning more than four hours. Several actions were of particular note, including:

1. Election of officers (Louise MacDonald, Treasurer; Joel Karlin, Secretary; Tom Allen, Vice-President; and Dave Martz, President);
2. Designation of the above four officers as the Executive Committee;
3. Announcement of Jack Berry's

impending retirement from clinical practice in October to accept appointment as Assistant Medical Director for RMHMO for the Front Range Area. (This necessitates his resignation from the CPN Board of Directors, and offers you the opportunity to suggest a replacement fitting the designation of Eastern Slope rural Primary Care Physician—call Kirsten at 303-694-2784 as soon as possible with your recommendations);

4. Physician Credentialling actions;
5. Marketing updates supplemented by BOD input;
6. Provider listing issues in published directories;

7. Response to fee schedule questions;
8. Consideration of "Continuity of Care" policy precedents by CPN; and,
9. A detailed presentation and discussion of a data collection system for clinical outcomes analysis.

Your input and communication with officer and Board members is strongly encouraged. We will be meeting monthly henceforth with our upcoming meetings scheduled for October 23 and November 13. Call Kirsten for details including Board member names and phone numbers. It's Happening Get involved NOW!



CMS numbers continue to rise

by Chet P. Seward
CMS Communications

Membership in the Colorado Medical Society has continued its steady rise in number over the past year. As of September, statistics show that membership has increased by over 100 physicians since January. This brings total membership to an all time high of 5,176.

Active members persist in shouldering the largest average increases. Currently, 79 percent of total membership consists of active members, bringing their total to 4,111.

Resident and student membership numbers declined steadily over the first two quarters of this year. Statistics show that trend is slowly reversing itself. Currently, residents and students comprise five percent of total membership with 277 members.

Members who did not renew their 1996 membership were dropped at the beginning of March, which accounts for the dramatic decrease in membership through the middle of April. (See figure below)

However, some of those members did eventually renew, and along with new members the graph below reveals the steady rise to the record level set in September.

These membership statistics demonstrate the increasing influence of organized medicine in Colorado. As health care reform continues, more Colorado physicians are finding solace in the unifying mission of the Colorado Medical Society.





visit to Robert Frost

by **Bruce C. Richards, MD**
Wheat Ridge, Colorado

Editor: This text is taken from notes made in 1957 by Bruce C. Richards, M.D., while he was an undergraduate at Middlebury College, Vermont. Dr. Richards received his medical degree from Wayne State University School of Medicine.



Robert Lee Frost, Poet
1874 - 1963

We started out, my friend Don Towne and me, from Middlebury College, headed for Ripton (VT). We knew he lived somewhere outside of Ripton (which is on the way up Bread Loaf Mountain) on the left-hand side of a dirt road. After we got out of Ripton a ways, we chose a road and started up. We met a man walking along with a lunch basket in his hand, a worker of some sort, and we asked him where we might find Robert Frost. He gave us directions: follow the road a bit further and then make a left turn up a very hard and narrow country lane. We did so, and when we reached the end of this lane there was a grey barn to the right and a not-too-pretentious house with peeling, grey paint on our left.

Coming down an overgrown slope ahead of us was an old man, walking slowly. This picture will always be in my mind. I wish I could adequately express what's in my mind. The man wore a cap and was dressed in black corduroy pants and a large denim work jacket. His hair was very white under the cap. He had a grey stubble of a beard on a ruddy freckled face. He wore large, thick-bottom shoes. He carried three garden tools, one of which was a small pickax. Lumbering gives a better description, a better picture of his walking. In front of him scampered a small, very friendly, wire-haired dog, barking as he ran up to us. After petting and playing with the dog, the man was near. We stood up.... and thus I met Robert Frost.

We told him we had heard his lecture the other night (at Middlebury College) and wondered if we could talk to him for a little bit. He

said that he was cleaning up a few things before he had to leave the country, but he would talk to us... for a little while.

As he led us up the stone steps of the house, I offered to carry his tools, but he quickly refused. We went inside the house, which had a rolling floor but seemed in complete accordance with the rolling hill country we were in, very much in harmony with the mountains of Ripton, Vermont. The room was, perhaps, a living room with several wooden chairs and a desk. There were books above the desk on a shelf. There was a table, and a faded rug covering the rolling floor.

As he offered us chairs he asked us where we were from. We replied Michigan and Boston. The conversation was light chitchat; however, it still contained some hints of the simple, worldly wisdom of the man we were talking to. He said "I suppose the usual thing is to ask what you are majoring in, but I don't give a damn." He said to Don that he supposed he was a literature major, and that is why we came to see him. Don replied that he was majoring in literature, but that wasn't why we came. Frost commented that he didn't know why you had to major in anything. I noticed that his hand shook a little bit and he showed his 83 years. He was a little hard of hearing and we had to repeat several things we said.

The conversation turned to skiing. He said "Skis take you to college and wings take you to heaven." He seemed occupied with this thought for the next few words. We talked for several minutes.

Editor: The CMS ARCHIVES by Historian Dr. John Lightburn does not appear this month because Dr. & Mrs. Lightburn have been on vacation. His articles will appear again in the December issue.

A visit to Robert Frost

(Continued)

I asked him if he read periodicals or newspapers. He told us how he read the newspaper: read the front page, then the Sports section (commenting that Detroit, as he glanced my way, wasn't doing so well), and then he would read any editorials that happened to catch his eye. Another comment on Detroit had to do with (Walter) Reuther who he said was trying to get wages for his workers.

He said that he wasn't a literary man who writes every day; he just wrote now and then. I asked him if he took Latin or Greek, and he said that back when he was in school this was the fashion. He also mentioned there was no skiing back in his school days.

About majors -- when I mentioned the psychology of why young people feel they have to major, they felt they had to have something under their belt to fall back on, he replied "I don't see why."

The conversation continued until we were interrupted by a phone call. Frost answered the phone and had a lot of trouble hearing. After he found out that they wanted Miss Morrison, his secretary (whom he calls his boss), and that the call was from New York, he asked the operator if the other party would like to talk to Robert Frost. The conversation on the phone was terminated by his saying to get in touch with Frost through his secretary as he was in the midst of things and couldn't give them any time on the telephone. He started to sit down again, seemingly willing to continue our conversation, but Don and I thought we had better leave so we said our good-byes. He started another conversation at the door. He said if the New York person found his number way up here in the Vermont mountains, he just couldn't give them a quick brush-off. He said "There is something in me that I can't give a quick brush-off."

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MEDICAL NEWS

Grant to help prevent underage and binge drinking at CU-Boulder

In October, the American Medical Association (AMA) and the Robert Wood Johnson Foundation announced the names of universities receiving grants in a seven year, \$8.6 million program to reduce underage and binge drinking, on campus and in surrounding communities. The universities, chosen for their innovative programs, are: The University of Vermont (Burlington), the University of Iowa (Iowa City), the University of Delaware (Newark), the University of Colorado at Boulder, and Lehigh University (Bethlehem, PA). "The schools that were selected have shown a determination to deal with a problem that almost every university shares," said AMA Chair Nancy W. Dickey, MD. She called the schools "national leaders in the fight to reduce underage and binge drinking".

The CU proposal is called *Learning the Boulder Way: Reducing High Risk Behavior, Rewarding Healthy Choices, Rebuilding Communities*. It will utilize the recommendations from standing committees on substance abuse to form a broad-based campus and community partnership task force to focus on four initiatives:

- research and evaluation;
- policies and enforcement;
- prevention, intervention and treatment;
- education and media.

Students, faculty and staff will be surveyed to determine alcohol-related behavior patterns and perceptions of alcohol-related issues. The information will be used to establish a baseline for measuring the success of the initiatives, said Jean Kim, vice chancellor for student affairs.

CU-Boulder will concentrate on strengthening and enforcing both campus and community policies and practices concerning alcohol acquisition and consumption. The program plan includes increasing options for alcohol abuse intervention and treatment on campus, as well as creating various support groups and a quick-response team. Perhaps the biggest challenge is changing the campus culture regarding alcohol. Education and media programs will be developed promoting the "health choices" theme.

Workers' compensation seminar

The Colorado Department of Labor and Employment, Division of Workers' Compensation, will present a Level II Physicians' Accreditation Seminar on November 22 and 23 in Denver. The Level II seminar is a series of lectures and workshops led by specialty experts on the administrative and legal aspects of the workers' compensation system. It also educates physicians on formulating impairment ratings utilizing the American Medical Association guides to the Evaluation of Permanent Impairment, 3rd Edition Revised.

For more information, please call Sharon Elenburg at (303) 575-8756 or Kay Bothwell at (303) 575-8763.

New regulations for audiologists/hearing aid dealers

Effective immediately, hearing professionals must register with the Colorado Department of Regulatory Agencies. Individuals must be registered as an audiologist or hearing aid dealer to fit, sell, or deal hearing aids in Colorado. Because this is relatively new program, it is recommended that physicians who refer patients to audiologists or hearing aid dealers should verify the hearing professional's registration. Please call Linda M. Fleming at (303) 894-2464 or (303) 894-2440 to check on registration status.

Focus group on regional air quality

The Regional Air Quality Council (RAQC) is conducting a series of focus group discussions in an effort to involve a broad range of community interests in decision-making about air quality in metro Denver. Before the RAQC begins drafting the *Blueprint for Clean Air*, focus groups will address questions such as: How clean do you think the air should be in the metro area? Given a list of potential strategies, which do you think is the most important? Which has the greatest chance for implementation?



CMS members are encouraged to participate in these facilitated, focus groups. Please call Adam Van de Water at (303) 629-5450 to learn more about the focus group process.

Fee to copy medical records increases

Effective November 1, 1996 the maximum allowable charge for copies of the first 10 or fewer pages that can be charged to a patient or his or her designated representative will be raised from \$10.00 to \$12.00. The per page charge (\$.25) remains the same. The Board of Health ruled that the changes are intended to account for past inflation and cost increases in the industry between 1990 and 1996. The change impacts both licensed health care facilities and individual health care providers.

Larimer County opens child advocacy center

The Larimer County Child Advocacy Center (LCCAC) will open its doors this month. The advocacy Center's mission is to facilitate cooperation between agencies dealing with child abuse in order to reduce harm to the child. The center eliminates unnecessary repetition, provides a central location where interviews, medical exams, and case coordination take place, and a child-friendly environment to help put children at ease. The combination of these factors not only reduces trauma to the child, they decrease red tape and excess workload for

Dr. Butterfield named alumnus to Columbia University College of Physicians and Surgeons

Dr. L. Joseph Butterfield was honored by the Alumni Association of the Columbia University College of Physicians and Surgeons for his work in getting a postage stamp issued in honor of Virginia Apgar. Named as the second ever alumnus to the College of Physicians and Surgeons, Dr. Butterfield explained that he was inspired by the work of Dr. Apgar.

Known for such medical achievements as the development of the Apgar score, a universally accepted evaluation tool for neonates, Dr. Apgar was instrumental in shaping the professional careers of many physicians. Dr. Butterfield's successful work in getting the 20-cent Apgar stamp produced is a



Dr. Butterfield (left) is conferred as an honorary alumnus by Alumni Association President John Schullinger.

tribute to the hard work and devotion to medicine which she engendered.

Dr. Butterfield is currently a professor of pediatrics at the University of Colorado.

caseworkers.

One of 15 similar advocacy centers in the state, the Larimer center has relied heavily on physician input. CMS member Dr. Deborah Crawford is on the advisory committee, and has assisted in developing the center since its inception. Similar plans in Pueblo, where physicians volunteer their services, and in Colorado Springs, where doctors supervise sexual assault nurse examiners, utilize on-site medical examining rooms to coordinate care and reduce stress on

abused children.

Child advocacy centers, like the one in Larimer County, assist physicians, other providers and law enforcement officials in breaking the cycle of violence.

For more information about the Larimer County Child Advocacy Center, or for information about similar programs around the state please call Nancy Lindemood, Executive Director of LCCAC, at (970) 224-6123 or (970) 407-9739.



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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

“. . . why do you keep answering?”

Have you noticed lately just how many people are wearing these telephone pagers? They've been very common among physicians for many years. You probably don't even notice other people's pagers. I still do.

I was standing in a fast-food line recently and I started checking people's pagers. I was amazed to find that a majority of people in that gathering had a pager, in view. Whether the device was working I don't know. The point of this is the pager is an indication of how we in the U.S., have given up our freedom for the sake of technology and "keeping up with the Joneses". We are now, nearly all of us, tethered by an electronic leash, and when someone tugs on that leash we feel compelled to respond or answer the demand.

Forty years ago I was accosted by someone who said "I called and called your house today. Why didn't you answer the phone?" I said, simply, "I didn't want to." This week I had a volunteer assignment to call 25 people on a list to remind them of an upcoming function. Of the 25,

I actually talked to seven. I got nine machine answers; one line had been disconnected, and no answer to the others. Those who answered probably have a machine as well. I just happened to catch them at a weak moment near a phone.

Years ago when I told that person I didn't want to answer the telephone, that was exactly what I meant. I had the telephone installed in my home for my convenience and pleasure. I was the master; the phone was my instrument. Today, the phone is the master, and we are the instruments. Few of us feel we can afford not to answer the phone, some way, even if it is by machine recording. We have trained ourselves that when we hear a telephone ringing sound we are compelled to answer it. Is it guilt or fear that makes us react this way to the telephone? When we're not near a phone (within arm's length) we depend on these pagers. I know people who travel a great deal and they even have **international** pagers.

No longer can we afford the luxury of saying "I want to live my life for me... not for the phone."

Technology has developed so rapidly that it has raced past generations. It is reported that the cellular telephone boom is rolling across China like a great wind. To thousands of Chinese buying cellular phones, these are their **FIRST** telephones., and generations of development have been **skipped over entirely**. How very sad. They possibly knew nothing of the

telephone, and little of life outside their province. Suddenly, in communication and technology, they are shoulder to shoulder with half the world's population.

How sad to think that cultures are being painted over, erased, by the broad brush of western technology. How sad to think that the communication revolution is literally wiping out chapters in the story of mankind's development. Pictures of many people and their strange art and tradition will never be seen by others, in person or in textbooks.

Yet, how ironic to think that a western technical creation is having such an effect on China, the birthplace of that greatest of all erasers, gunpowder, the ultimate instrument of practically every other revolution (and whose use has obliterated generations of people the world over).

Like yourself, I have some favorite telephone stories. I was in the radio news room one morning and the phone rang. I answered "Good morning, K ___" and the lady caller said "Room 614." I said "Ma'am, this is a radio station." She said "I called St. Joseph Hospital." I said "You called the wrong number." She repeated this exercise three times, and then on the fourth time....

Me: "Good Morning, K ___."

She: "I want Room 614!"

Me: "Ma'am, this is still the wrong number."

She: "Well then, why do you keep answering?" . . . and slammed down the phone.

PRESIDENT'S LETTER



M. Ray Painter, MD, FACS
President, 1996-1997



As a physician, you are honest and well intentioned. You treat your patients fairly and bill for the services you perform as accurately as you know how. The subject of fraud may rarely cross your mind. Yet you are probably guilty of abuse and perhaps fraud according to the standards utilized by Medicare auditors. Most of us are not at risk of going to jail, however, a majority of us are at risk of having to pay large penalties.

How can this be? We are not flagrantly charging for services not rendered or patients we haven't seen. Nor are we participating in a scam run by companies that rent durable medical equipment or provide home health care service to patients who haven't used it or don't need it. "No," you say, "I am doing none of those things, and I'm certainly not guilty of fraud". But wait a minute, I must repeat, most of you are guilty of abuse and perhaps fraud in the eyes of Medicare and their "Fraud Squad". Read on and I will explain.

If Medicare were to audit your charts, could the following potentially fraudulent actions be detected?

- **Charging for services not delivered**— Do you have routine fees that occasionally are not actualized? An example might be a urinalysis that may have been charged to a patient who could not give a specimen that day.
- **Charging for services not properly documented**— For example, if a complete urinalysis were performed, but the chart merely states "UA normal", then the charge is

not valid without chart documentation of all the elements of a UA. Yes, I know you "always" perform a complete UA. Such a failure to document the rendering of a complete UA does not count in the eyes of the law!

- **Altered diagnosis to achieve payment**— A patient comes into the office for a routine yearly physical exam. A diagnosis or symptom of a disease is used in order to receive payment from Medicare.
- **Changed CPT code to achieve payment**— Your office personnel found out that the assigned code accurately reflecting the service provided is not a payable encounter by the patient's insurance company in that specific situation. Another code is "pretty close" to the service provided, which is paid by the patient's insurance, so you charge the "close" code.
- **Charging for E&M service for which proper documentation was not made**— For example, a level two was charged for a new patient in which the examination of only one organ system was documented.

Civil money penalties which do not carry criminal charges, as contained in the new Kennedy-Kassebaum bill also elevate the potential for fraud. Three specific areas are of interest:

- **Upcoding**— a process defined as charging for a higher level of EM service than has been documented. Documentation per code level is very precise and "exact". The Kennedy-Kassebaum bill includes a provision for civil

"You do not have to be intentionally dishonest, or purposefully plan to defraud the government to be guilty of abuse."

(Continued on following page)

PRESIDENT'S LETTER (continued)

money penalties to apply to persons who engage in a pattern or practice of presenting a claim for an item or service based on a code that the person knows or should know will result in greater payments than appropriate.

• **Medically unnecessary**— This area has the potential to be a huge problem! The Kennedy-Kassebaum bill assesses penalties on persons who engage in a pattern of submitting a claim that the person knows or should know is for a medical item or service which is not medically necessary.

• **Certifying home health services incorrectly**— If you sign an order, which is later proven to be incorrect, indicating that a patient is eligible for medically necessary home health services, then you are responsible and will be held liable for abuse and perhaps fraud.

Summary

The point of this discussion is very simple. You do not have to be intentionally dishonest, or purposefully plan to defraud the government to be guilty of abuse. The new law states that a person is subject to its fraud provisions when a person presents a claim that the person "knows or should know" falls into one of the prohibited categories.

On the brighter side, the rules are precise. This means that HCFA has to follow the rules in auditing your practice, just as you're required to follow the rules in billing your services. If you know the rules and follow them, then you will have no problems.

The good news is that most physician offices are trying to comply and have attempted to learn the rules of the new coding system. These offices should not have problems. If the offices are audited, they will be reviewed for possible

abuse, not fraud. These types of audits are conducted by the local Medicare Carrier not the Office of Inspector General (OIG). (The OIG gets involved when there is a strong suspicion of intent to defraud the Medicare Program.) The bad news is that if a Medicare audit identifies abuse, it could cost you lots of money in projected overpayments.

Taking the time to learn these complex and sometimes illogical rules is difficult for physicians and personnel. However, with a little resolve, as well as a little cooperation with the coders and office managers, you can learn the system, bill according to rules, and avoid not only the act of fraud but the fear of fraud. It's just not that difficult! If you have any questions please call Marilyn Rissmiller in the CMS Health Care Financing Department. She know the rules.

LEGAL UPDATE

Auto Insurance

In Colorado, more insurance policies do not necessarily mean more coverage.

In a recent decision in the case of Shean v. Farmers Insurance Exchange, the Colorado Court of Appeals considered whether the coverage available under multiple insurance policies from the same automobile insurer can be "stacked" to provide the aggregate amount of total coverage available under the policies. This interesting case involved a serious automobile accident, in which the driver of a van and his six passengers suffered serious injuries or were killed. Because the other driver who caused the accident did not have

sufficient insurance, the van driver and his passengers sought to recover underinsured motorist benefits under four separate policies that were issued to the driver of the van. Each of these policies had coverage limits of \$100,000 per occurrence, which the injured parties sought to aggregate for a total coverage amount of \$400,000. Unfortunately, each of the policies had language that indicated that Farmers' coverage responsibility was limited to the highest amount on any one of the policies issued by it. The Court of appeals upheld this position, and ruled that the total available coverage was \$100,000 for all of the injured parties.

from Gelt, Fleishman & Sterling P.C.
Denver, Colorado
(303) 861-1000

This case is very important to any insured who may have multiple insurance policies issued by the same company. A close examination of your policy terms is essential, so that you can determine whether such "anti-stacking" language may limit your potential recovery if you or one of your passengers is injured in an automobile accident caused by an uninsured or underinsured driver.

For further information please contact:
A. Craig Fleishman, Managing Director
Gelt, Fleishman & Sterling P.C.
1600 Broadway, Suite 2600
Denver, Colorado 80202
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CMS Med Fax[®]

...a compilation of medically-related news briefs of immediate interest to the physician community occurring after **COLORADO MEDICINE** has gone to press.

AT PRESS TIME...

CMS Med Fax[®]
by **Montgomery Little and McGrew, P.C.**
legal counsel to the Colorado Medical Society

Continuity of care principles endorsed by CMS and CHMOA

The Colorado Medical Society (CMS) and the Colorado HMO Association (CHMOA) have come to an agreement on a protocol ensuring that patients with special needs will be assured of continuous, quality care when they move from one health plan to another.

The *Recommendations for Transition of Care for Patients with Special Needs* follows months of discussions between CMS and CHMOA. It applies specifically to those patients with chronic or protracted illnesses under the care of a primary care or specialty care physician during a time of transition. The framework is simple and flexible. It compensates the transferring physician for the time and effort expended, gives highest priority to concern for patient satisfaction, and promotes an effective vehicle for health plans to transition potentially high cost patients into their plan.

The specific elements of transition include: early

notification; identification of patients with special needs and circumstances; transition planning visit; transfer of patient information; introductory visit to accepting physician; physician to physician consultation; and compensation.

"This agreement reaffirms that decisions about appropriate care are between the doctor and his patient, our member, and there is an understanding about how the new plan should be advised about the care required by the member", said Steve O'Dell, President of the Colorado HMO Association and executive V.P. of Blue Cross & Blue Shield of Colorado. Dr. Painter noted, "The agreement goes a long way in assuring continuous quality care for patients with special needs that are forced to shift from one health care plan to another. Its adoption by individual HMOs will provide a mechanism for a smooth transition without interruption".

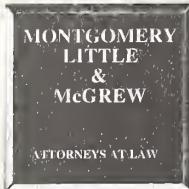
(Continued next page)

Independent Medical Examiners needed

The Colorado Division of Insurance is now accepting applications from a variety of different types of licensed health care providers in Colorado to serve on an "Independent Medical Examiner" (IME) panel for auto accidents. In 1996, the State Legislature enacted Senate Bill 96-78, which authorized the creation of a mechanism for the timely investigation and resolution of disputed personal injury protection claims arising from auto accidents. Under this new program, insurance companies or patients will be able to select an IME from a list of five qualified providers, to provide a second opinion about the reasonableness, necessity, and accident-relatedness of the care rendered. That list will be impartially selected from all providers on the panel by IME Administrators, LLC. Providers will be paid their reasonable fees by the party requesting the IME.

To qualify for membership on the panel, applicants must have credentialing in certain specialty areas, possess a current Colorado license as a health care practitioner, not have spent over 50 percent of their professional time or derived 50 percent of their professional income conducting IMEs or serving as expert witness in any of the last three years, and have completed the IME Panel Application Form. Applicants must be able to attest to their qualifications to perform IMEs in their specialty area, and have experience in that specialty providing treatment to accident victims. Providers must agree to abide by the program guidelines for examination and reporting standards.

Please call 894-7499 for the list of provider specialties or write to: IME Administrators, LLC., 4100 West Colfax Ave. Box 16, Denver, CO 80204.



Med Fax: Medico- Legal News

by Karen B. Best, Esq., an associate with the law firm of Montgomery Little & McGrew, P.C.

This column contains information concerning topics of general interest in the medical-legal field. For further information or help with specific problems, please contact Montgomery Little & McGrew, P.C.

Physician income study: How are you doing?

A study published in the journal *Health Affairs* found physicians' net income fell four percent in 1994. The drop was attributed by the researchers to (what else?) the impact of managed care. According to the study, the average physician's income dropped from the equivalent of \$195,300 in 1993 to \$186,600 in 1994. The largest declines in income were reported in states where managed care made the deepest penetration.

Physician-assisted suicide

The U.S. Supreme Court (the "Supremes") has agreed to hear two cases challenging state laws banning physician-assisted suicide. A New York state law makes it a crime for a physician to prescribe a lethal dose of medication requested by a terminally ill patient. The federal appeals court found that the New York law could not single out terminally ill patients not on life support and deny them the right to alleviate their suffering and hasten death, when patients with similar prognoses on life support could have their support systems withdrawn. Another federal appeals court struck down a Washington law banning physician-assisted suicide on due process grounds. Reference: Quill v. Vacco, No. 95-1858; Washington v. Glucksberg, No. 96-110.

Colorado law makes it a crime both to commit suicide and to assist in the commission of suicide. Physicians are not exempt from the law.

Note: Former Surgeon General C. Everett Koop urged Congress to prohibit any Medicaid funding for assisted suicide: "Society must not allow doctors to be killers as well as healers." How would you bill that anyway?

Almost a New Year: Almost New Promises

FTC promises speedier ALJ decisions: New guidelines adopted by the FTC are intended to speed

up its handling of cases involving antitrust complaints, consumer protection matters, and challenges to corporate mergers. Effective January 1, 1997, the rules force administrative law judges (ALJs) to issue their decisions within 12 months after a complaint is filed. A fast-track decision process guaranteeing both the ALJ ruling and commission's final review within 13 months will be offered in merger cases. Although a year may seem an interminable length of time to resolve an FTC matter, under the current system it can take years to conclude complex cases going before an ALJ. Companies often choose to settle enforcement actions rather than contest the charges. Query: Will the new rules encourage more antitrust complaints, consumer protection actions, or challenges to corporate mergers, and discourage settlements, and as a result further clog the system?

Insurers will cover 48-hour hospital stay for childbirth: The House and Senate, before going home to face the "Soccer Moms" and future "Soccer Moms" in the final weeks before the election, shot through legislation requiring health insurers to cover 48-hour hospital stays for normal deliveries and 96 hour stays for Caesarian deliveries. Unlike similar statutes in about two dozen states, the federal law (effective January 1, 1998) applies to businesses that self-insure.

Insurers will not impose lower lifetime limits on mental health benefits: Other recently passed legislation will do away with private insurers' widespread practice of setting lifetime limits on mental illness benefits lower than those for physical illnesses. Now, that disparity is often 20:1 — \$50,000 versus \$1 million in lifetime benefits. Certain escape hatches in the new provision will prevent a substantial rise in insurance premiums: it only applies to businesses with more than 50 employees, starting January 1, 1998; it will not force insurers to offer or provide mental health coverage at all; it will not prevent insurers from imposing separate co-payments and deductible to mental health benefits; employees could still be charged more out of pocket to see mental health professionals, and face limits on the number of allowed visits. Moreover, businesses that can demonstrate that the change will increase their premiums by one percent or more are eligible for exemption.

Continuity of care (from page 1)

The principles will be presented to the 17 member plans of CHMOA, who will individually decide whether to adopt them as a matter of policy.

Look for more details on this issue in the January edition of *Colorado Medicine*.

CMS Med Fax

CMS indigent physicians trust fund

The Jane Nugent Cochems Trust was established to assist indigent physicians in the state of Colorado. The President of the Colorado Medical Society selects the recipient, in a confidential manner, based on recommendations from other member physicians. The principal remains intact and the interest only is dispersed on an annual basis, in November or December.

The Colorado Medical Society is now accepting suggestions. If you know of a challenged colleague that would benefit from this trust, please call the CMS Executive Office at (303) 779-5455 or 1-800-654-5653 as soon as possible. The trust grant will be awarded at the end of this year, so please call with your nominations today.

Remember the children this holiday season

There are thousands of children in Colorado who are healthy on the outside, but hurting on the inside. They are hurting from an emotional disorder or mental illness. And you can help by supporting the Mental Health Association of Colorado's (MHAC) *Remember the Children Campaign* this holiday season.

For each \$20 donation, a teddy bear is given to a child with mental health needs. This year, 2,000 teddy bears will be given to children and youth at community mental health centers, hospitals and community agencies serving children with mental health needs.

MHAC is a nonprofit education and advocacy organization working to eliminate the stigma of mental illnesses and to increase access to mental health treatment. Every \$20 contribution made to sponsor a teddy bear goes exclusively to supporting MHAC's children's programs.

For a brochure, please call MHAC at (303) 377-3040, ext. 33.

Let's Talk brochures still available

The CMS Board of Directors, leadership and staff have created a new doctor-patient relationship brochure entitled "Let's talk: An open letter to my patients." The brochure is an open letter from physicians to patients detailing the features of the newly enacted "Gag bill" (HB 1216), reinforcing physician commitment for patient advocacy and stressing the importance of open doctor-patient communication.

While many CMS members have requested the brochure, many more have not. The perfect informational piece for your waiting room, this brochure is available free of charge by calling the CMS Communications Department at (303) 779-5455 or 1-800-654-5653. If you need more, or if you have not ordered any yet please call.

Let's Talk



An open letter to my patients

-Thank you-

The Colorado Medical Society would like to thank Denny Lezote, Ph.D. and the University of Colorado Health Sciences Center for their help in assisting in the creation of the new CMS Internet site.

Corrections

The November edition of *Colorado Medicine* erroneously reported that Dr. Joseph Butterfield had been named the second ever alumnus to the College of Physicians and Surgeons. Dr. Butterfield is the second ever *honorary* alumnus.

CMS Med Fax

Colorado Medical Society provides the following listings of events as a member service only. Some events are approved for Continuing Medical Education credits. Information is provided by the sponsoring organizations. For more details, use the telephone contact at the end of the listing.

American College of Cardiology

The 28th Annual Cardiovascular Conf. at Snowmass
January 13-17, 1997
Snowmass, Colorado
CME Credit: 22 Category 1 AMA
1-800-253-4636 ext. 695

Disease Management Congress

Implementation and Outcomes Measurement
January 14-17, 1996
San Francisco, California
800-446-6422

Colorado Hospital Association

JCAHO - Accreditation Standards for Home Care
Organizations-The Advanced Course
January 14-15, 1997
Denver, Colorado

Contact: Peggy McCreary at (303) 758-1630

HIV Clinical Training Program

Col. AIDS Education and Training Cntr. and
UCHSC
January 15-17, 1997
Denver, Colorado
(303) 355-1305

American Diabetes Association & Colorado Society of Endocrinology

33rd Annual Colorado Diabetes/Endocrinology Inst.
January 18-23, 1997
Aspen-Snowmass, Colorado

1-800-782-2873

American College of Cardiology

Cardiovascular Conference at Snowbird
February 12-14, 1997
Snowbird, UT
1-800-253-4636 ext. 695

Colorado Hospital Association

Preparing for the DOJ: DRG 3-Day Window Proj. Prgm.
February 14, 1997
Denver, Colorado

Contact: Peggy McCreary at (303) 758-1630

Colorado Society of Osteopathic Medicine

Ski & CME Midwinter Conference
February 23-28, 1997
Keystone Lodge & Resort, Colorado

CME Credits: 39 hours AOA Category 1-A CME crdt
Patricia Ellis (303) 322-1752 or 800-527-4578

American College of Cardiology

The 4th Annual Workshop on 2-D and Doppler
Echocardiography at Vail
February 24-27, 1997
Vail, Colorado

1-800-253-4636 ext. 695

American Lung Association

16th Annual Big Sky Pulmonary & Critical Care Med. Conf.
March 20-22, 1997
Big Sky, Montana
(406) 442-6556

The Prosper Meniere Society

6th Symposium and Workshops on Inner Ear Medicine
and Surgery
March 22-29, 1997
Aspen, Colorado

Contact: Jane Wells, (303) 788-4235

Colorado Hospital Association

19th Annual Rural Hospital Conference
April 30-May 3, 1997
Breckenridge, Colorado

Contact: Peggy McCreary at (303) 758-1630

Colorado Hospital Association

JCAHO - Managed Behavioral Health Care: Standards and Survey Process
May 19, 1997
Englewood, Colorado

Contact: Peggy McCreary at (303) 758-1630

Colorado Medicine

Cumulative Index

Volume 93, 1996

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Sandra L. Maloney, Executive Editor
William S. Pierson, Managing Editor
Chet P. Seward, Administrative Assistant

Note: ALL CAPS in an index listing indicates a regular department. Prefixes such as "Dr.", "the" and the like have been removed from the listings for more useful alphabetization. authors appear last name first; MD or DO designation do not appear after the names for ease of use of the index.

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Sandra L. Maloney
Executive Director
Colorado Medical Society

As you know, CMS is engulfed in improving our communications techniques via the Internet and other telecommunication technology. While we are using this technology to communicate with you, others are using it in other ways. You have heard it referred to as *telemedicine*. What is telemedicine? What impact will it have on you the practicing physician? Will it create or solve problems? What are the implications to patient care?

Telemedicine is defined as "the use of telecommunications technology by physicians to engage in the practice of medicine (within a state or across state lines)".

Telemedicine also includes real-time clinical consultations and store-and-forward applications such as teleradiology/telepathology image transfers.

The components of telemedicine may include any or all of the following issues:

- infrastructure planning and development
- regulation
- reimbursement
- licensure and credentialing
- medical malpractice liability
- confidentiality
- economic impact/turf issues

Hmm.. *telemedicine*?? The "tele" aspect is being looked at by cable companies, phone companies... you name it! Who should be looking at the "medicine" aspect? Should it be those involved in the provision of medical care?

A long time ago a few of us believed that patient care would be "managed" by a third party. Lo' and

behold, before we knew what hit us, the managed care plans were very much a part of the health care delivery system. We found ourselves reacting to the problems rather than being proactive.

There is a belief that telemedicine is and will continue to change the way in which medicine is practiced. Should we wait and see what happens and then react? Is it simply *new* technology coupled with medicine as we know it today? Or is it new technology coupled with *new* medicine? Perhaps it is a little of both.

CMS needs your help in determining a realistic approach to this subject. Please consider the questions listed below and provide us with your comments. You may phone or fax us your response. Please call (303) 779-5455 or 1-800-654-5653. Fax your responses to (303) 771-8657.

- What role do you think is appropriate for CMS in the evolution of telemedicine?
- Has telemedicine come knocking at your office door?
- Remembering the components of telemedicine listed above, are there any we have left out?
- What problems can you identify that can be tied to telemedicine?

Your input on this issue is greatly appreciated. The information you share will provide us with the data needed in order to determine an appropriate strategy. Thanks for your help.

"Should we wait and see what happens and then react?"

“It’s the best prevention program I’ve seen.”

— William Gonda, MD, San Francisco

“This program makes it easy for me to routinely discuss firearm safety.”

— Marilyn Bull, MD, Indianapolis

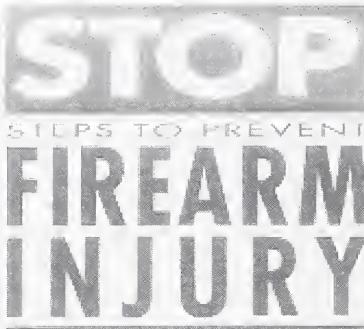
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— Michael Clemmens, MD, Annapolis

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A joint program of the American Academy of Pediatrics and the Center to Prevent Handgun Violence

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City

State

Zip

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D ecision '96

by Lorraine Koehn, Director
CMS Department of Government Relation

"COMPAC contributed to a total of 55 contested races and had a 91 percent success rate for selecting winning candidates."

Falling back on the old adage, "I'll let my colleagues do it" will only weaken the political voice of organized medicine. Time has now run out and medical families *must* become involved in the election process prior to 1998. Passage of the Campaign Reform Amendment will make personal involvement in the election process mandatory if the Colorado Medical Society (CMS) is to remain a major player in the state legislature.

This amendment sets maximum contribution limits at \$200 per election cycle to State Senate and State House of Representatives candidates (half of this amount during the primary and half during the general election). Independent expenditures by persons/political committees are not limited, but there are new disclosure requirements. Immediate (within 24 hours) reporting to the Secretary of State is required for independent expenditures more than \$1,000. Advertisements paid for by independent expenditures more than \$1,000 must disclose the identity of the person making the expenditure, the amount of the expenditure and a specific statement that the ad is not authorized by the candidate. *Corporate and union contributions are prohibited.*

CMS expects that the provisions of this Amendment will not only necessitate increased individual physician involvement, they also require more effort by COMPAC and staff. This is a statutory change, not a constitutional amendment, so the General Assembly could make changes to it. CMS considers this a

remote possibility since the amendment passed by such a large margin.

The upcoming reconstruction of the legislature and campaign reform set the stage for an extremely heavy work load during the next election cycle. There are 27 veteran legislators (nine Senators and 18 members of the House of Representatives) who cannot run for reelection in 1998 because of term limitations. Few legislators have the personal resources that allow them to finance campaigns which can cost between \$14,000 to \$100,000. These costs are in addition to any mailings candidates may utilize to communicate with their constituents. The cost of mailings alone is often in the \$4,000 to \$5,000 range. A legislator's reimbursement for serving is \$17,000. Unless we are prepared to assist with their expenses, one must question how CMS can preserve the high quality makeup of the legislature.

House Republican leadership has chosen Representative Norma Anderson to be house majority leader. She is the first woman ever to hold the post in Colorado. Rep. Anderson succeeds Rep. Tim Foster, Grand Junction, who did not run for reelection. Rep. Jeanne Faatz was reelected assistant majority leader; Gary McPherson was named caucus chairman, and Doug Lamborn, Colorado Springs, will serve as majority whip.

House Democratic leadership has chosen Rep. Carol Snyder to be the new house minority leader, replacing retiring Peggy Kerns. Ken

(Continued next page)

Gordon was elected as assistant minority leader. Gloria Leyba will serve as caucus chairman and Ron Tupa was named minority whip.

Senate majority leadership remains the same with Tom Norton as president, Jeff Wells as majority leader, Ray Powers as assistant majority leader and Bill Schroeder as caucus chairman.

Senate minority leadership has undergone some change. Mike Feeley was renamed minority leader, Bill Thiebaut is the assistant minority leader, and Pat Pascoe replaces Bob Martinez as caucus chairman.

COMPAC contributed to a total of 55 contested races and had a 91 percent success rate for selecting winning candidates. COMPAC also provided contributions to 20 legislators who did not have opponents. These funds were to assist the legislators with mailings to their constituents.

Thanks to each of you who took the time to call COMPAC leadership and the CMS Government Relations Department with recommendations on candidates and comments concerning the CMS position on the Parental Rights Amendment. All your calls were appreciated. CMS encourages you to remain involved. Please keep us apprised of future conversations with your legislators on issues of importance to CMS. Physicians who would like regular legislative updates should forward your fax number to the CMS Department of Government Relations at (303) 779-5455 or fax your request to (303)771-8657.

Key Contacts needed— Staff is in the process of updating the CMS Key Contact Program, focusing specifically on finding physicians willing to serve as a key contact for the 17 new state legislators listed below. CMS members should contact the CMS Department of Government Relations if you know any of these legislators and are willing to serve as a resource person to those individuals.

NEW LEADERS IN THE STATE LEGISLATURE

State Senate

(There is a 20/15 split between Republicans and Democrats.)

Ken Arnold (R), Westminster, replaces retiring Lloyd Casey (D).

Jim Congrove (R), former state representative from Arvada, replaces retiring Sen. Al Meiklejohn (R).

Ken Chlouber (R), former state representative for Leadville, defeated incumbent Sen. Linda Powers (D), Crested Butte.

Peggy Reeves (D), former state representative from Ft. Collins, replaces Sen. Bob Schaffer (R) who won his bid for U.S. Congress, 4th Congressional District.

Terry Phillips (D), Louisville, replaces retiring Sen. Paul Weismann (D).

House of Representatives

(There is a 40/25 split between Republicans and Democrats.)

Kay Alexander (R), Montrose, replaces retiring Steve Acquafresca (R).

Stephanie Takis (D), Aurora replaces retiring Don Armstrong (D).

Dan Grossman (D), Denver, replaces Diana DeGette who was successful in her bid for the First Congressional Seat.

Matt Smith (R), Grand Junction, replaces retiring Majority Leader Tim Foster (R).

Dorothy Gotlieb (R), Denver, replaces retiring Doug Friednash (D).

Steve Johnson, DVM, (R), Loveland, replaces retiring Bill Jerke (R).

Suzanne Williams (D), Aurora, replaces retiring Peggy Kerns (D).

Jennifer Veiga (D), Denver, replaces retiring Wayne Knox (D).

Mark Udall (D), Boulder, replaces retiring Peggy Lamm (D).

Penn Tate III (D), Denver, replaces retiring Glenda Swanson Lyle (D).

Bill Sinclair (R), Colorado Springs, replaces retiring Bill Martin (R).

Gayle Berry (R), Grand Junction, replaces retiring Dan Prinster (D).

Bob Bacon (D), Ft. Collins, replaces Peggy Reeves (D) who moved to the Senate.

Tambor Williams (R), Greeley, replaces retiring Pat Sullivan (R).

Paul Zimmerman (D), Thornton, defeated incumbent Eric Pinzler (R).

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Call for Nominations

The Secretary of the Colorado Medical Society (Executive Director, Sandra L. Maloney) has announced a **Call for Nominations** for the following offices of the Colorado Medical Society:

President-elect

Vice Speaker of the House of Delegates

AMA Delegate

AMA Alternate Delegate

The CMS Executive Office is now accepting nominations for those expressing an interest in the above offices. Please call Debbie Jones at (303) 779-5455 or 1-800-654-5653 if you have any questions.

Physician Recognition Awards

The Colorado Medical Society joins the American Medical Association in recognizing the following physicians for their dedication to excellence in the profession of medicine, as demonstrated in their commitment to continuing medical education.

Susan Ray Frederick
Caroline M. Gellrick
Monica Anne Lawry
Roger W. Narvaez

Perlita G. Acuna-Narvaez
Marc Roger Peck
Kenneth Anthony Richeaux
Anne C. Wentz

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 **NCPIE**
666 Eleventh Street, NW
Suite 810
Washington, DC 20001



by John Lightburn, MD
Historian
Colorado Medical Society

Serving the indigent

Two months ago, we presented a brief biographical sketch of Dr. Gerald Webb in which we chronicled how the physician coped when his bride of 22 months became ill with tuberculosis. Dr. Webb was only one of many physicians who came to Colorado seeking a cure for tuberculosis. One hundred years ago, one third of all practicing physicians had come to Colorado with tuberculosis in themselves or their family. They brought to the state skills and knowledge as well as an empathic understanding of the ill patient. Our medical community was enriched by their presence.

The impact of tuberculosis on Colorado was enormous. Literally thousands of consumptive "came seeking the cure promised by seductive railroad advertising and boastful chambers of commerce. The magic of our climate was called the "elixir vitae". Those who came seeking health outnumbered those who came seeking gold and silver. Trains arrived daily packed with immigrants from the crowded urban centers of the United States and Europe. Some were so ill they had to be carried off the train, and many others were penniless. At first welcomed as additions to the growing community, they became an unwelcome burden and a threat to the health of the populace. At one time, one third of Colorado's residents had active tuberculosis. One out of every four died of tuberculosis. And 80 percent would be infected by the age of 20.

Most of these invalids remained in Denver or Colorado Springs where medical facilities for indigent

tubercular were not available. The county hospital had only a few beds, and the poor invalids wandered the streets searching for a place to rest and food to sustain them. Rooming houses, rest homes, private homes or tents were available to those who could scrape together a few pennies. Some lived on the streets. The citizens of Denver were ambivalent in their response to the plight of these unfortunates, trying to deny their presence. Fortunately, a few humanitarians responded. In 1894, the Reverend Frederick W. Oakes established the Oaks Home on west 38th Avenue for "that class of refined and cultured men and women (consumptive) who find it not an easy thing to secure healthful surroundings ...within their means". He eventually expanded his "home" to accommodate 150 patients. The building still exists today a few blocks east of the original Elitch Gardens.

Frances Wisebart Jacobs, a well known member of the Jewish community, was one of the first persons to recognize the needs of these patients. She worked tirelessly for the indigent consumptive, visiting their homes, assessing their needs and returning with food, coal and a few bars of soap. With compassion and humor, she ministered to the individual invalid. This experience gave her a clear understanding of the health care crisis and the need for a community supported institution for the care of the penniless tubercular. Her first efforts to arouse public and newspaper support were unsuccessful, but she persisted. She found an ally in the energetic young rabbi of

"We consecrate this structure to humanity, to our suffering fellowman, regardless of creed."

—Rabbi William S. Friedman

(Continued next page)

ARCHIVES (Continued)

Temple Emanuel, Rabbi William Sterne Friedman. With his leadership, the Jewish community came to the support of the "tender-hearted woman with a dream and the



Beck Archives, Univ. of Denver

Rabbi Friedman was a founder of the National Jewish Hospital.

aggressive young rabbi with a vision". In 1889, Rabbi Friedman persuaded the leaders of his congregation to form the Jewish Hospital Association. Their goal was to build a hospital for the destitute tubercular patient. Frances Jacobs' dream was to become a reality. Prodded by Jacobs and Friedman, they raised the funds, bought the land and drew up the plans. But she never lived to see the fulfillment of her dream; she died of pneumonia in 1892 at the age of 49.

Frances Jacobs had devoted herself to charitable work at all levels, not only in the Jewish community but in all of Denver. She was an early advocate of woman's rights and started the first free kindergarten in Denver. She founded charitable organizations, served on their boards and helped in raising funds. Collaborating with leaders in the Christian community, she helped in the consolidation of all Denver's charities into the Charity Organization Society, the forerunner of the Community Chest and then the United Way. She was called the "mother of charities". Her portrait in stained glass was installed in the dome of the state capitol with fifteen other prominent pioneers. Frances Jacobs is the only woman so honored.

Following the memorial service for his ally, Rabbi Friedman forged ahead with plans to erect and open a hospital. Land had been purchased at the corner of Jackson and Colfax

on the eastern edge of the city in 1890. By 1893, a building was completed at a cost of \$42,000, and was appropriately named the Frances Jacobs Hospital.

But the Frances Jacobs Hospital never opened. The "silver panic" of 1893 plunged the nation into a deep depression, and supporters of the hospital were no longer able to honor their original pledge of support. So the building stood vacant for six years while the need for a treatment facility continued to grow.

During the six years that the Frances Jacobs Hospital was closed, Rabbi Friedman worked for its reopening. He soon realized that the burden of supporting a free hospital for indigent patients was more than the local Jewish community could support. Working with other leaders in the Jewish community, they developed a plan to enlist the help of B'nai B'rith in establishing a national base for financial support. This made it a national hospital, and thus the Frances Jacobs Hospital became the National Jewish Hospital, opening in 1899 as the first tuberculosis sanitarium in Denver.

Tuberculosis was a serious and stubborn disease that required long term care with medically supervised diet, rest, exercise and environment. Such a treatment plan was not available in the ordinary hospital. With this in mind, Dr. Edward Trudeau opened the nation's first tuberculosis sanitarium at Saranac Lake, New York in 1883. This

provided the model for the nation, and the "sanitarium movement" was born. It was not until 1899 with the opening of the National Jewish Hospital that the sanitarium movement came to Colorado. During its first year, 149 patients received care there, most of whom were not residents of Denver.

Concern for the many Jewish persons in Denver with advanced tuberculosis prompted a small group of people, most of whom had at one time harbored the tubercle bacillus, to meet for the purpose of devising a means to help destitute Jewish consumptives in Denver. "A collection was made and the magnificent sum of \$1. 10 was raised". That was how Dr. Charles Spivak, one of its founders, described the origin of the Jewish Consumptive Relief Society (JCRS). From this humble beginning, JCRS grew quickly and in one year had twenty acres of farm land on west Colfax with six tents. Within another year, a three story brick building had been erected and there were twenty tents. Like National Jewish, there was no charge to the patient; support came from charitable donations, primarily from the local Jewish community.

Other sanitaria were established in Colorado. Among them were: the Boulder Sanitarium by the Seventh Day Adventist Evangelical Lutheran Sanitarium in Wheatridge, Swedish National in Englewood, Bethesda in Arapahoe County and Senator

(Continued on following page)



National Jewish Medical Research Center

The Frances Jacobs Hospital was built in 1892. Economic depression prevented it from opening until 1899 as National Jewish Hospital.

Lawrence Phipps Agnes Memorial even miles east of Denver and Glockner and Cragmoor in Colorado Springs.



Dr. Spivak played an instrumental role in founding JCRS.

Other than National Jewish and JCRS, there was virtually no provision for the indigent patient with tuberculosis. The state made no provision for its own indigent citizens. There were two small non-profit facilities. In 1909, a young tubercular student from Ohio, Frank Craig, set up his tent in Edgewater. He was joined by other men, solicitations were made and within a

year Craig Colony, a tent sanitarium, was established for fifty consumptive men. In 1913, a tubercular young woman knocked at the door of a Denver Home and collapsed in the arms of the lady of the house. This lead to the establishment of Sand House in 1915, a forty bed home for destitute tubercular women.

National Jewish and JCRS were conceived and built at a time when medical care was seen as a service, not as a business enterprise. Patients were not profit centers. Local physicians volunteered their services without charge. The two institutions grew in size and excellence, provided for research and training, and served our community with distinction. With such institutions succeeding, what happened to bring about our current system of managed care? Can history provide a clue?

We cannot finish this article without paying tribute to Rabbi Friedman and Dr. Spivak. Their efforts on behalf of indigent tubercular has left a lasting legacy in this state.

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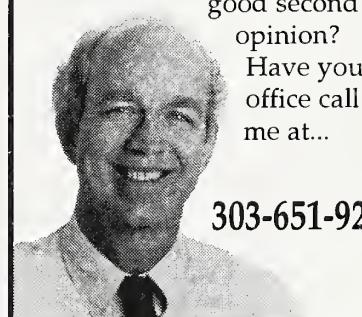
"It's just too much!" You couldn't tell for sure if her apparent depression is secondary or primary. All she wants to do is talk about how hard life is emotionally. You prescribed meds, and you think she needs someone to talk to — *who's good and you can trust.*

And now that you think about it, *you'd* like to talk to someone about her. You'd like to consult with someone who can help you sort out her emotional state from her medical symptoms.

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Michael Smith, Ph.D.

- Private practice, 1983 to present
- Faculty, The Naropa Institute, 1996
- Faculty, Institute of Transpersonal Psychology, 1983-1996
- Workshops for physicians
 - *Handling Your Own Grief*
 - *Dealing With Patients' Emotions*
 - *Understanding Depression*
 - *Handling "Practice" Stress*

Medicare's Correct Coding Initiative: Definitions and Examples

by Marilyn Rissmiller,
CMS Health Care Financing Department

Part two of a two part series

The Correct Coding edits that have been built into the Medicare processing system are based on the different policy definitions noted below. Practical examples of these definitions have been provided for additional clarification.

1. CPT Procedure Coding Definition:

The CPT procedure code definition, or descriptor, is based upon the procedure being consistent with current medical practice. In order to submit a CPT code to Medicare, the physician must have performed all of the services included in the code descriptor. Otherwise, a less comprehensive code (comp. code) must be billed. Physicians must not submit the individual procedure codes (which describe components of a comprehensive procedure code) in addition to the comprehensive procedure code. *Components are services necessary to accomplish the more comprehensive procedure/service.*

Example:

*Comp. Code: 11042 – Debridement; skin and subcutaneous tissue
Component Code: 11040 – Debridement; skin, partial thickness*

Code 11042 is considered the comprehensive procedure code and the component code 11040 would be bundled into it. Code 11040 would be denied if it was billed separately.

2. CPT Coding Manual Instruction/ Guideline:

In addition to CPT procedure code definition, instructions and guidelines in CPT are provided either as an introduction to CPT sections or as parenthetical references.

Example:

*Comp. Code: 99291 – Critical care, evaluation and management
Component Code: 71010 – Chest x-ray; single view, frontal*

At the beginning of the critical care category there are instructions which indicate that several services

are included when performed during the critical care period. Code 71010 is one of those mentioned and would therefore be bundled into 99291.

3. Mutually Exclusive Code Pairs:

These codes represent services or procedures that, based on either the CPT definition or standard medical practice, *would not or could not reasonably be performed during the same session* by the same provider on the same patient. Codes representing these services or procedures cannot be submitted together.

Example:

Column I: 71020 – Chest x-ray, two views, frontal and lateral

Column II: 71111 – X-ray of ribs, including posteroanterior chest, minimum of four views

Note: Medicare will only pay the lesser valued procedure (Column I) when two mutually exclusive codes are billed together. (Refer to the information on the GB modifier for exceptions.)

4. Sequential Procedures: When it is necessary for a physician to attempt several procedures in direct succession during a patient encounter to accomplish the same end, *only the procedure that successfully accomplishes the expected result* is reported.

Generally, this occurs when a less extensive procedure fails and requires the performance of a more extensive procedure. Failed procedures followed by more extensive procedures should *not* be billed separately. Procedures that are often performed in

(Continued next page)

sequence have been identified and the less extensive procedure has been bundled into the more extensive procedure.

Example:

More extensive: 20250 – Biopsy, vertebral body, open; thoracic

Less extensive: 20225 – Biopsy, bone, trocar or needle; deep (vertebral body)

5. Separate Procedures: Although certain CPT codes are identified as "separate procedures", HCFA has determined that these codes may be occasionally provided as part of a more comprehensive procedure. In those instances, even though the codes have a designation of "separate procedure", they should not be submitted in addition to their related and more comprehensive codes.

Example:

Comp. Code: 32100 – Thoracotomy, major; with exploration & biopsy

Component Code: 32020 – Tube thoracostomy

6. Most Extensive Procedures:

When CPT descriptors designate several procedures of increasing complexity, only the code describing the *most extensive* procedure actually performed should be submitted.

Example:

Most extensive: 93015 – Cardiovascular stress test...with physician supervision, with interpretation and report

Less extensive: 93000 – Routine ECG with at least 12 leads; with interpretation and report

7. "With" & "Without" Services:

Certain CPT descriptors designate procedures performed "with" or "without" other services. *Submit only the code describing the service actually performed.*

Example:

Comp. Code: 81000 – Urinalysis, by dip stick or tablet reagent...non-automated; with microscopy

Component Code 81002 – Urinalysis, by dip stick or tablet reagent...non-automated; without microscopy

(Continued next page)

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8. Sex Designation: Certain CPT code descriptors identify procedures requiring a designation for male or female. Submit only the appropriate one of these designations for an individual patient.

9. Standards of Medical Practice: Medicare considers all of the services necessary to accomplish a given procedure to be included in the description of that procedure as defined by CPT. Ancillary services necessary to accomplish the procedure are considered included, although independent CPT codes may exist for these ancillary services. Medicare considers billing for these independent CPT codes unbundling, which is prohibited.

Example:

Comp. Code: 20600– Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (e.g.: fingers, toes)

Component Code: 64450– Injection, anesthetic agent; other peripheral nerve or branch

Because the block (64450) is being performed for the primary procedure (20600) it is not reported separately. It is considered bundled into the primary procedure.

10. Laboratory panels: When CPT describes laboratory services performed as a panel or grouping, submit the appropriate code describing the panel or grouping. Do not submit codes for individual laboratory tests when a code for a grouping or panel exists for the services performed.

Example:

Comp. Code: 80061– Lipid panel
Component code: 82465– Cholesterol, serum, total

Component code: 83718– Lipoprotein, direct measurement; HDL

Component code: 84478 – Triglycerides

If all of the individual tests within the Lipid panel code are performed, you must submit the panel code.

services, when it implemented the correct coding edits. "The physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day". This may represent:

- a different session or patient encounter;
- a different procedure or surgery;
- a different site, separate lesion, or separate injury (or area of injury).

When the GB modifier is used appropriately, it will prevent erroneous denials. The GB modifier should be appended to the procedure with the **higher** value (the code listed in Column II of the CCI manual). **Examples:**

- 11640 GB– Excision, malignant lesion, face, ears, eyelids, nose, lips; 0.5 cm or less
- 17000– Destruction by any method...all benign facial lesions or premalignant lesions in any location....; one lesion.

Without the modifier Medicare's system assumes both surgeries were performed on the same lesion and denies the **higher** valued procedure.

Examples:

- 71020– Chest x-ray, two views, frontal and lateral (Performed on patient in the office in the morning, diagnosis was pneumonia.)
- 71111 GB– X-ray of ribs, including posteroanterior chest, minimum of four views (Performed on the same patient in the office in the afternoon, after falling.)

Without the modifier Medicare's system assumes both x-rays were taken at the same time and denies the **higher** valued procedure.

The Correct Coding Initiative is not easily understood because it is so complex. It can cost you money in terms of inappropriate denials. There are numerous reference books available to assist you (including the PRS SourceBook). CMS can also assist you. Please call Marilyn Rissmiller in the CMS Health Care Financing Department at 779-5455 ext. 2428 or 1-800-654-5653 if you have any questions.

GB MODIFIER For Use With Mutually Exclusive Code Pairs

HCFA added modifier GB for identification of distinct procedural



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Important Financial Services Survey

In January the HWC Group/Merrill Lynch will offer financial services to Colorado Medical Society members. This new financial program features an educational program based on the financial information needs of the membership. The survey below is a crucial element in determining those needs. It is not intended to elicit personal information, nor is it intended to sell any services of the HWC Group or Merrill Lynch. Your responses will assist in formulating seminars and educational programs that will best serve the wishes of the entire membership. Strict confidentiality will be observed. Please answer the questions below and then mail the survey to: **Colorado Medical Society, P.O. Box 17550, Denver, CO 80217-0550, Attn: Member Services.**

1. How has managed health care affected your practice? (Grade one through five, one being the least positive)

- A. Positively _____
- B. Negatively _____
- C. Not felt much either way _____

2. Please identify your preferred method of communication. (Grade one through five, one being the least positive)

- A. Mail _____
- B. Telephone _____
- C. FAX _____
- D. E-mail/Bulletin board _____
- E. Media _____
- F. Seminars _____
- G. Internet _____

3. Can you suggest ways in which improved communications and information handling by Colorado Medical Society can aid you in your medical practice? **Yes** _____ **No** _____

A. If you answered YES, please comment: _____

4. If you have access to the Internet, do you think that it can be used in a manner that could assist you in your practice? **Yes** _____ **No** _____

A. If you answered YES, please explain: _____

5. Do you currently use E-mail? **Yes** _____ **No** _____

A. If you answered YES, how could E-mail be used to exchange information between you, CMS and HWC Group/Merrill Lynch? _____

(over)

(CMS/HWC Group Survey continued)

6. How would you rank your needs for financial services? (1 not much – 5 very much)

- A. Mortgage or financing services _____
- B. Trust services _____
- C. Estate planning services _____
- D. Investment services _____
- E. Insurance services _____
- F. Business planning services _____

7. Would you like to see "personal finance" articles in *Colorado Medicine*? Yes _____ No _____

A. If you answered YES, specifically what kind of articles would be of interest?

1. _____
2. _____
3. _____
4. _____

8. Do you have a written business plan? Yes _____ No _____

- A. Updated annually? Yes _____ No _____
- B. Do you use an advisor? (attorney, consultant, etc.) Yes _____ No _____

9. Do you have a written personal financial plan? Yes _____ No _____

- A. Updated annually? Yes _____ No _____

10. How are your investments actively managed? _____

11. Do you have a financial advisor? Yes _____ No _____

12. How often do you review all your insurance needs? _____

13. Do you have an insurance advisor? Yes _____ No _____

14. Do you do an after tax cost analysis of your liability management for your business?

Yes _____ No _____

15. Personally? Yes _____ No _____

16. Beginning in January 1997, HWC Group/Merrill Lynch will offer priority financial services. Will you be interested? Yes _____ No _____

Optional

Name: _____ Phone #: _____

Thank you for your cooperation!



Colorado Medical Society endorses financial service group

by David Halsch, Vice President
HWC Group at Merrill Lynch

Effective January 1, 1997, The HWC Group at Merrill Lynch will begin providing priority priced financial services to the Colorado Medical Society members. We at HWC group, would first like to say that we are honored by the endorsement of your organization. Our commitment is to provide the highest level of customer service possible to all members.

Our team concentrates on the financial and investment needs of individuals, small businesses, and retired clients. We stress a long-term approach to investing and emphasize financial planning to help our clients determine their financial needs and risk tolerance. However, we accommodate investors for whom a short-term speculative investment approach may be appropriate. Portfolio performance and client satisfaction are our primary business objectives.

Our two senior partners are David P. Halsch, VP Senior Financial Consultant and John W. Warner, Assistant VP Senior Financial Consultant. David has been with Merrill Lynch for 16 years and assists clients with fixed income, retirement planning, financial and estate planning services. John W. Warner has over 13 years experience in the financial services industry and has been with Merrill Lynch for 9 years. He assists clients in municipal bonds, business financial planning, insurance, and liability management.

John and David work in conjunction with other members of HWC Group to provide superior support in both administration and investment research. Collectively,

the team has over 50 years of experience in the financial service industry.

HWC Group provides a wide array of products and services as well as local specialists in the following areas:

- Corporate Executive Services
- Credit Management
- Estate Planning
- Financial Planing Services
- Insurance
- Retirement Planning Services
- Trust Services

Our products and services include:

- Advisory and professional investment management services
- Certificates of deposit
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- Money Market Funds (taxable and tax-exempt)
- Mortgages
- Mutual Funds
- Municipal bonds
- Pension plan services
- Tax-deferred annuities
- US Treasuries
- Zero-coupon bonds

Our goals are to establish efficient channels of communication with members and provide superior service. Included in this issue of

Colorado Medicine is a survey* that will help us in accomplishing these goals. We hope you will take some time to complete this survey. The HWC Group can be reached at (303) 689-8012 or, toll-free, at 1-800 408-6364, by E-Mail at David_Halsch@ml.com or by mail at 6400 S. Fiddler's Green Circle, Englewood, CO 80111.

What are your financial questions?

* Survey form on pp 403-404

Changing the paradigms of physician-patient communication

by Joseph Dwoskin, MD
CMS Committee on Medical Informatics



"We are changing from the Industrial Age of medicine to the Information Age of medicine."

The winds of change in medicine are blowing stronger. The paradigm of today is not going to be the paradigm of tomorrow. This applies not only to the amount and type of medical knowledge we use, but also to the methods of communication we use with each other and with our patients.

With the evolution of the computer, we are changing from the Industrial Age of medicine to the Information Age of medicine. Industrial Age medicine saw the doctor as the traditional authority figure. Little thought was given to the many social aspects of how medicine was practiced. Moreover, almost no consideration was given to informing patients, significant others and caregivers about diagnoses and treatment options to allow them to be part of the decision process.

Today that paradigm is changing. Insurance companies, managed care, Medicare and Medicaid have

affected physician's attitudes because they have interfered with the traditional doctor-patient relationship.

Time is now a function of the changing financial structure in American medicine. The physician simply does not have time to spare, and must work at a fast pace just to keep up. Dealing with the business aspects of the practice of medicine require more time, and all of this affects attitudes toward patients.

There are many anecdotal stories of communication failures between doctors and patients. I interviewed several people to assess attitudes and found that these patients wanted more information, but used different methods.

Some went to another doctor for a second opinion. Another used a friend's information for the same diagnosis. One said that American medicine has Alzheimer's disease because doctors do not communicate well with each other or with patients. One patient with a serious diagnosis started a web page here in Colorado to assist others in obtaining health information on the Net.

The Internet can save time and improve communication. There are over 10,000 sources of medical information for patients on the Internet. These multiple sources are in response to the changes in attitudes by all concerned. When you consider that about 100 million Americans have chronic illnesses and 35 percent of households have computers, then you can understand why utilization of the Internet to learn more about medicine is only going to increase. Other evidence, which states that the average income

of Internet users is \$61,000, suggests that patients who do use the Internet are intelligent and successful.

There are some well known physicians who have significantly contributed to the growth of patient self-help networks. Commercial computer networks, internet mailing lists, news groups and web pages are all available. Self-help networks gather, store and translate technical medical information into forms most useful to group members.

Many self-help groups recruit selected professionals to serve as consultants. The responsibility of those physicians is to be a facilitator and advisor, not an authority figure or parent.

Doctors must learn to deal with patients who come to the examining room with accurate, often new, information about their diagnoses. We must be helpful and not critical of those who just want more information about themselves.

What does the future hold? Physicians will give patients information about the World Wide Web to inform them about websites and other resources that can help patients find the information they need. A computer will be in the consulting room, and the latest information will be printed out for both the patient and the medical record. E-mail contact with patients will be the norm in a few years. It will save office visits, it will probably be compensated, and it will be included in the patient's record.

The Information Age is here. We as physicians can help shape it to benefit our patients and be a responsible addition to our practices.



CMS goes online with new Internet website

by Chet P. Seward,
CMS Communications

The web of communication between the Colorado Medical Society (CMS), member physicians and their patients is spreading into cyberspace. On January 1, CMS will officially launch its new Internet website. Designed to harness the informational power of the world wide web, the CMS Internet site opens a new universe of opportunities to improve communication and provide better service to member physicians and their patients.

The CMS website has four main sections – What's New, CMS Info, CMS for Physicians and CMS for Patients. Each domain is designed to enhance the society's mission of advocating for excellence in the practice of medicine for physicians and patients.

What's New contains information about current CMS activities. Details on new CMS programs like the Physician Profile Project, the Colorado Rural Outreach Program (CROP), and domestic violence education and resource information can be found here. Other efforts, including such informational brochures as *You and Your Doctor* and *Let's talk: An open letter to my patients*, are highlighted.

CMS Info brings you into the offices of the medical society. The primary function of this domain is to keep you abreast of CMS meetings, publications and policies. You may scroll through the rosters of various CMS task forces and committees, or peruse recent and current editions of *Colorado Medicine*. The CMS policy manual can be browsed using a search mechanism to verify the society's stance on relevant issues.

Other features include a calendar of events and a listing of county society offices.

CMS for Patients is designed to qualitatively improve the doctor-patient relationship by providing patients with the information and the tools they need to become more actively involved in both their health and their health care. This section contains news on the latest public health issues and spotlights some of the medical society's patient advocacy efforts. For example, domestic violence prevention and protection resource information are accessible here. Answers to commonly asked questions about doctors, like how to transfer medical records, can also be found here. A select list of health care websites, including the AMA, the Center for Disease Control and the Federal Drug Administration, link patients to other online resources.

CMS for Physicians focuses on the information that physicians need to practice better medicine. Physicians can click on a carefully selected list of health care websites to be connected to the latest clinical information, health news, practice management guidelines and medical libraries via the Internet. Links to component societies and a directory of selected health care phone numbers will assist you in gathering information or contacting institutions like the Board of Medical Examiners, the Department of Health and Environment or local hospitals. Nonmember physicians can obtain information about how to join the society and gain licensure in Colorado.

"The site creates a new continuum of communication, cooperation and care between the Colorado Medical Society, physicians and patients."

(continued next page)

(Continued from previous page)

CMS for Physicians will also feature a members only section. Exclusive member services and other important information will be listed here. Log on procedures and passwords will prevent unauthorized use. Continuing medical education (CME) courses in Colorado will be posted and members will be able to follow the progress of selected task forces and committees. A special legislative tracking option will keep you up to date on the latest developments at the state capitol. Current health care bills, CMS position, and their status will be displayed. Plans are being made to create special legislative briefs which will allow readers to e-mail their state representatives or senators with their support

of or opposition to particular legislation. Resource materials, like brochures and the PRS SourceBook, can be electronically ordered by members. The latest press releases and other publications from the CMS Communications Department will be available, and there will also be direct links to CMS staff to answer other questions you may have.

The utility of the Internet was originally doubted. Today any remaining misgivings have been squashed because the information/communication potential of the web continues to grow. Instant access to information 24 hours a day, innovative, immediate response mechanisms, and more than 125 years of experience providing services that physicians need all characterize what the CMS Internet site offers.

"The CMS website is a great, new communication tool. It will save doctors, staff and patients time because they have the information they need right at their fingertips," notes CMS Executive Director Sandi Maloney. The site creates a new continuum of communication, cooperation and care between the Colorado Medical Society, physicians and patients. It will assist Colorado physicians in ushering in the next century of quality health care. However, as Maloney asserts, "physicians must also do their part. They have to utilize it!" Please visit the CMS Internet site at <http://www.cms.org> often. Tell your patients and colleagues about it, and then let us know what you think.



Cyberspace driver's education

"Warning – Dangerous driving conditions exist." It seems ironic to see such signs posted on many of Colorado's highways, yet no such caveats exist for today's cyberspace travelers. In some ways driving on ice packed mountain passes is safer than cruising the Internet. It is dangerous to ignore recent data, but it is also perilous to flatly accept statements, studies and conclusions from something as volatile and unregulated as the World Wide Web. Yet patients and physicians are speeding to the web to learn more about medicine and health care. One thing is for certain, doctors must approach and utilize the web with professional caution.

A fledgling web – Despite the hype it is important to remember that the World Wide Web is only a few years old. Databases and other indexes have been available online for more than a decade. Yet "gophers" (text-only processors to the web) were just created in the early 1990's. Thus, most of the information on the web is relatively new. If you are looking for an obscure

reference from 1953, the odds are that you will not find it on the web. While the amount of information currently available on the Internet is astounding, physicians must realize that there are limits to how far back information is available.

Gluttony is good!? – The Internet provides access to tons of information. Some have called it a black hole or the "infoglut" provider. The beauty of the Net is that it is a continually changing medium of publication. You can view, copy and republish information quite easily. While much of it is free, some medical and scientific journals charge for access to or copies of specific articles. Other databases, like Medline, charge for time or per citation. Sometimes studies are accessible on the Internet before they are even published in hard copy form. The important thing to remember is that the web is an information tool. If used properly it can be an endless source of data. It can also be an amazing way to blink away hours at a time. Doctors can and must use medical Internet

resources, discussion lists, listserves and other libraries to stay on the ever changing highway of medical information. Access to some of these resources will be available in the *CMS for Physicians* section on the new CMS Internet website.

Take it with a grain of salt – With a little practice, finding the information you want can be easy. One of the most apprehensive aspects of the Internet is that the information found there is not always accurate. Government agencies, managed care organizations, businesses and individuals all flood the web with information. Before any data is assumed to be fact, it is critical to assess who actually published it. What may appear as conclusive evidence, may be the off-the-cuff conclusions of a quack plumber in Poland posing as a physician. Do not rely on information from one source, especially if it comes from a discussion group. If you find an obscure reference, in all likelihood you can discount or verify it by using a different search engine.

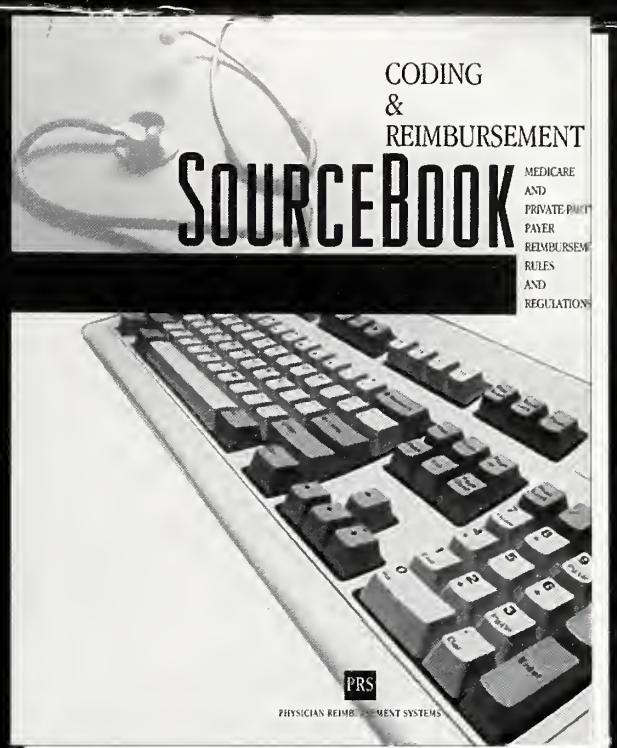
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- State specific information

Updated three times a year, the *SourceBook* is available to CMS members for the discounted price of \$132. Compare this discount to the non-member rate of \$184, plus \$15 shipping and handling!

For more information, call Marilyn Rissmiller in the CMS Health Care Finance Department at 779-5455 or 1-800-654-5653.



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What's in the cards?

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If you're like most Bridge players, you're always hoping for good cards. Well, here's one solution: These cards are always good! CMS, in celebration of its 125th Anniversary, has produced these Bridge decks, excellent for gifts or for your personal use, printed with the Colorado Medical Society seal in gold on a red back, they are Bridge size plastic coated linen cards.

They're just \$4.25 per deck including postage and handling. All proceeds go to the Colorado Medical Foundation, so this is one bridge hand that's a win-win-win situation.

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C. R.O.P. plowing through Phase I

by Suzi Shevell,
CMS Health Care Policy

Phase one of the Colorado Rural Outreach Program (CROP), the planning study, has begun. Despite the germane sounding nature of this part of the program, the Colorado Medical Society (CMS) Resource Development Committee has been hard at work planting seeds for future success. Much has been learned and there is much more left to be done.

Peter Milstein, development consultant to the CROP, is in the process of conducting confidential interviews with corporations, foundations and individuals state-wide. From the interviews, the CROP Advisory Committee hopes to gain better understanding of the direction this project should take. A complete report on the planning study will be available in late December.

The CROP will be an evolving entity, continuously re-crafted and remolded until it addresses the needs of as many physicians and communities as possible. As the planning study continues, some of the underlying premises of the program have been scrutinized. Specifically, the CROP's definition of "rural", originally considered as being quite broad, may be too narrow. CMS staff attended the Colorado Opportunities Fair in September and learned that some communities in need of physicians do not fall within CROP defined standards, and therefore may not participate in the program. As a result, the CROP Advisory Committee revisited the definition of "rural" during a recent meeting.

Why does a simple definition seem to be such an important part of

the design of this program? Because the CROP Advisory Committee wants to be certain that *any* rural community in need of a physician will be eligible to participate in this project. Existing loan repayment programs have a restriction attached to eligibility. Communities that wish to participate must be federally designated as Health Professional Shortage Areas (HPSA). Specific guidelines, like having a ratio of population to full time equivalent primary care physicians of at least 3,500 to one, must be met in order for a community to be designated as an HPSA. The CROP Advisory Committee believes that other factors, such as the impending retirement of currently practicing physicians and the need to create a more ideal physician to patient ratio, must be considered when determining eligibility in the CROP.

The Committee has approved plans to begin an all out effort to conduct rural community outreach initiatives. CMS staff is working with the Colorado Rural Health Center in Denver to develop a survey of needs. The survey will be mailed to a variety of individuals, clinics, hospitals, county health departments and physicians currently practicing in the rural environment. The CROP Advisory Committee hopes the results from the surveys will help to learn more about the individual needs of communities, and how programs like CROP can be most useful to all participants. Future outreach plans include arranging informal focus groups to discuss potential challenges for the communities in question.

"Other factors, such as the impending retirement of currently practicing physicians and the need to create a more ideal physician to patient ratio, must be considered when determining eligibility in the CROP."

Colorado Physician Network, Inc.



by David C. Martz, MD, President
Colorado Physicians' Network (CPN)

Marketing of Rocky Mountain Physicians' Choice in the Denver-Metro area is expected to begin January 1, 1997. Following extensive discussion, and based on a poll of the membership and several Town Meetings in the Denver-metro region, it has been decided to unify the Provider Directory to include both CPN and RMHMO providers in a single directory. There are several advantages to this approach:

- It will increase the number of Primary Care Physicians in that area from 208 to 573, and the total Denver-Metro participating physicians from 1,149 to 2,523. This will make the product far more attractive to purchasers who previously would have been reluctant to accept a program with only 208 PCPs.
- It will avoid confusion among the brokers and purchasers about having two similar programs with similar

names (Rocky Mountain HMO and Rocky Mountain Physician's Choice). This will greatly simplify and enhance our marketing efforts and facilitate a much larger sign-up of recipients.

- It will provide opportunity to give new momentum to the marketing effectiveness for all providers benefit. The RMHMO product has not been aggressively marketed in Denver-Metro, and the penetration has been limited. This fresh approach of a single, seamless program advertised with new "sizzle" will bring life and vitality to the Front Range.

Denver-Metro RMHMO physicians who have not previously joined CPN may choose to join CPN now, or participate as contract physicians for the time being. Should they elect the contract relationship, they will not have the opportunity to share in either profitability or governance until they join CPN formally. Meanwhile, both CPN and RMHMO practices can enjoy the enhanced enrollment of purchasers

made possible by the unification. Referrals can be made within the entire directory, and reimbursement rates will be preserved as they currently exist as long as market pressures allow.

Almost 50 percent of the 400 physicians polled by CPN (one half CPN only and one half CPN-RMHMO affiliates) responded to the poll! Of those, 90 percent supported the unification proposal. Three Town Hall Meetings were held and were well attended, at which endorsement approached 100 percent following more detailed discussion of the issues than was possible by the mailed poll. The CPN Board was unanimous in recommending this step, and the RMHMO membership and leadership are strongly supportive.

Clearly our strength lies in **unity**. This has been our most central core value from the outset, and must be our commitment always. And so we take one more step to bring our dreams and goals to reality as we unify our efforts to "Make it Happen!"

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**THE NUMBER 1 REASON YOUR PATIENTS
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EVERY YEAR AFTER 50



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CopicComment

by Jerome M. Buckley, MD
Chairman & CEO
Copic Insurance Company



Looking Back and Looking Forward

It's December, and soon the bustle of the holidays will sweep us along in its wake. Before we know it, it will be 1997. With the promise of the new year bright before us, it seems fitting to look back at the accomplishments of the past twelve months.

Copic began 1996 with an ambitious goal...to work with its partners to formulate a proactive response to requests for provider-specific data. No doubt, you've heard of the furor and concern that greeted the physician profiling effort launched recently by the Massachusetts Medical Society. With dedicated collaboration from Copic, the Colorado Medical Society, and Gadian Corporation, Colorado's own Physician Profile Project was launched in February without intrusive legislation and with the direction and cooperation of Colorado physicians. The Project continues to grow and enjoy broad support from the physician and patient communities.

In June, Copic again took action in anticipation of physician needs. This time, the issue was the physician site visits required by NCQA when managed care

organizations seek accreditation. Recognizing that these visits can be time-consuming, disruptive, and duplicative, Copic developed Practice Quality, LLC. This new company, which conducts the site visit and medical record review components of the NCQA provider credentialing process, began marketing its services in early summer. Practice Quality's process and proprietary software allow them to conduct a single, highly-efficient, minimally disruptive site visit and then share the data across the multiple managed care organizations with which the physician has contracts.

The past year also witnessed the introduction of several important new products and services. Copic's free coverage for retired physician volunteers means that for the first time ever, retired physicians who wish to provide medical services without pay can do so without exposing themselves to substantial personal liability. Our capitation stop-loss coverage, which debuted in early 1996, helps lessen the financial risk for physicians with HMO contracts. We were also able to assist and protect our insured

physicians by launching our managed care contract review service in June.

We closed the year as we began it...with an ambitious goal. Copic challenged itself to respond to physician requests and ride the technology wave by creating a presence on the World Wide Web. That goal was achieved on November 1, when Copic went online at <http://www.copic.com>. The web site greatly expands our customer service capabilities by making the information you seek available instantaneously 24 hours a day, seven days a week.

As we begin the new year, we are well positioned to meet its challenges. Our Board of Directors will benefit from the energy of its new members and experience of its long-term members, and our management and staff will continue to be dedicated, flexible, and innovative in their work and responsible with your premium dollars.

From all of us at the Copic family of companies, our best wishes for a peaceful and prosperous holiday season and new year.

Will your voice be heard by the legislature in the coming session?

The answer is yes, because you helped elect legislators that are supportive of organized medicine. COMPAC had a 91 percent success rate in selecting winning candidates in the recent elections. Join COMPAC today, and voice your support for those who will protect the practice of medicine tomorrow.





MEDICAL NEWS

All medical licenses to expire on May 31, 1997

All Colorado medical licenses will expire May 31, 1997. In order to receive the renewal application, a physician must have a *correct* "address of record" on file with the Medical Board. If you have moved from the location where you last received the Board's newsletter and have not yet updated your address or are planning a move before March 1, 1997, please submit the change in writing to Colorado Board of Medical Examiners, 1560 Broadway, Suite 1300, Denver, CO 80202, or fax it to (303) 894-7692, Attention: Susan Snook.

Do not rely on your mail service to forward the packet in time to renew your license. By law, only one renewal notice is sent, therefore, it is necessary to allow plenty of time for address changes to reach the Board and be processed.

Please be advised that there is a 60 day grace period for license renewals. Licenses which are not renewed in a timely manner will be put in a "lapsed" status on August 1, 1997.

New processes and procedures have been implemented for those physicians whose licenses are currently in an "inactive" or "lapsed" status. If you currently hold an inactive or lapsed license and plan to reactivate it please contact the Board prior to January 31, 1997.

For further information regarding address changes, license status or other related matters please call the Board of Medical Examiners at (303) 894-7690.

COLA makes new laboratory achievement program

The Commission of Office Laboratory Accreditation (COLA) recently unveiled a new laboratory achievement program. Developed in response to calls for demonstrated quality through education and testing, the program provides educational products and a certificate of achievement for laboratories or other facilities involved with Waived or Provider-Performed Microscopy (PPM).

"Testing facilities need a competitive advantage as third party payers and consumers alike are demanding quality. COLA will be among the first to provide recognition to excellent laboratories performing testing at the Waived and PPM levels," said COLA's CEO J. Stephen Kroger, MD.

Among other things, the Laboratory Achievement program includes:

- preparation of the HCFA forms necessary for a new Waived/PPM certificate for the Laboratory Director's signature;
- individualized procedure manual based on the facility's test menu;
- Quality Control and Quality Assurance forms;
- Quality Assurance Plan;
- Two year subscription to bimonthly newsletter, *COLA Update*;
- Personalized, step-by-step feedback on how to improve the laboratory practices based on a self assessment.

For more information please call COLA Customer Service at 1-800-981-9883.

Hepatitis C network and support system

In response to the growing outbreak of hepatitis C infections, the Colorado HepC Connection was created in November 1995 to assist hepatitis C challenged individuals. According to HepC Connection statistics, 3.9 million Americans are currently infected with the disease. Twenty-thousand cases were diagnosed in Colorado in 1995.

The HepC Connection provides up-to-date medical information and sound treatment options through telephone communication, newsletters and educational seminars. It also maintains group support focusing on the reinforcement of shared personal experiences and honest, ongoing encouragement. The network and support system helps individuals and families deal with the disease stigma and to adjust to the dietary and fatigue demands of this condition.

For more information please call Ann Jesse at 393-9395.

Hone your stop smoking message

There may be a better way to get your patients to stop smoking than repeating the same old phrase: "You've got to stop smoking". There is a way to tailor your message according to your patient's readiness to stop smoking. The American Stop Smoking Intervention Study (ASSIST), sponsored by the Colorado Department of Public Health and Environment and the Colorado Division of the American Cancer Society, has trainers, videos and ways to order



free patient information. Health care providers can learn counseling tips, stages of behavior change and how they apply to smokers and chewers, and how to talk to patients during a regular office visit.

Nearly 600,000 Coloradans smoke or chew tobacco, and 4,000 die each year because of it. As you know physicians can make a big difference. Honing the message may be the solution. To schedule a 45 minute training please call (303) 270-3301 or 1-800-473-2288. If you would like to receive a free video or information about ordering patient education materials call (303) 692-2513.

Federal Government's health program makes the grade – again

A recent survey of employees and retirees enrolled in the Federal Employees Health Benefits Program (FEHBP) has found that 87 percent of fee-for-service and 85 percent of HMO enrollees are satisfied with the overall performance of their health plans. Enrollees rated their health plans in five key areas: access to care, quality of care, doctors' availability, coverage, and customer service and paperwork.

With respect to specific aspects of health care, the survey also found that 93 percent of people covered by traditional fee-for-service health plans and 88 percent of those covered by HMOs are satisfied with the quality of care they receive from doctors and medical facilities participating in the program. Another 94 percent of fee-for-service

customers and 89 percent of HMO customers claim overall satisfaction with their access to medical care.

Survey results were based on the actual responses received from more than 55,000 FEHBP enrollees.

The United States Office of Personnel Management (OPM) administers the FEHBP, the nation's largest employer-sponsored health insurance program. The program covers more than nine million federal employees, retirees and their dependents.

The survey results may reinforce the claim that employer sponsored health plans, which offer a large choice of plans and encourage employees to pick the plan which best suits their needs, can effectively provide access to quality, cost-effective care.

AMA superhero joins battle against tobacco

America's kids in the fight against tobacco have a new champion. "The Extinguisher" and his mentor creator, "Doctor Nola Know," are the AMA's new cartoon superheroes. Their mission is to educate and protect children from the dangers of smoking. Together, they will help kids wage their own battles against the tobacco industry's advertising and marketing campaigns targeted toward America's youth.

The super duo will be featured in a new AMA nationwide public health campaign aimed at teaching elementary school-age children about the dangers of smoking and nicotine addiction.

A study published in the *Journal*

of the American Medical Association in 1991 showed that children as young as six years old were as familiar with Joe Camel as they were with Mickey Mouse, and that such familiarity is a known risk factor for smoking and tobacco addiction. The AMA has vowed to stop the tobacco industry's attempts to replenish the ranks of smokers who die prematurely from tobacco-related diseases.

Capitation may falter without strong physician support, research concludes

The new Capitation Sourcebook concludes that the structure of capitation, rather than the reimbursement mechanism itself, is the key to gaining physician support in today's marketplace. Published by renown health care analyst Peter Boland, this new resource book is a timely source of information on capitation.

"The squeeze being put on physicians and hospitals through capitated reimbursement is beginning to backfire on many health plans," notes Boland. "While payment mechanisms like capitation were intended to weed out inefficient practices by putting more financial risk on providers, it has forced many to develop their own health plans. HMOs will either have to reconsider provider compensation or lose physician support entirely."

The book illustrates how many successful HMOs and other providers have challenged the practice of controlling doctors by lowering payment. Call 1-800-437-7030 for more information.



CLASSIFIED ADVERTISING

Publication of any advertisement in Colorado Medicine is not an endorsement by the Colorado Medical Society of the product or service. Colorado Medicine magazine is the official journal of the Colorado Medical Society, and is authorized to carry General Advertising.

◆ PROFESSIONAL OPPORTUNITIES

SEEKING PEDIATRICIAN – St. Mary Corwin Medical Group in Pueblo, CO is expanding. Currently the group is comprised of 6 IMs, 6 FPs and 1 Ped. Call is shared w/other peds in community. Contact Jean 1-800-796-1964. 03/1196

GERIATRICIAN-PACE site in Denver looking for innovative physician to join growing program for the frail elderly. Strong multidisciplinary team, capitated system, small organization allows freedom practice to obtain goal of maintaining the elderly at home instead of nursing homes. BE/BC FP or IM, CAQ in Geriatrics, or fellowship a plus but not necessary. Competitive salary; great Rocky Mtn lifestyle. Contact Willie Orr, Total Longterm Care, 3202 W. Colfax Ave., Denver, CO 80204 or call (303) 573-8123. 03/1096

INTERNAL MEDICINE - A variety of Internal Medicine opportunities are available through Lutheran Health Systems in northeastern Colorado. Community sizes vary from small to large. Competitive benefit packages, excellent educational systems, and a variety of recreational opportunities are available. Strong medical staff and complete hospital services in the region. If interested, please send your CV to: Sherry Kozero-Roth, North Colorado Medical Center, 1801 16th Street, Greeley, CO 80631 or FAX (970) 350-6644. 03/1096

FORT COLLINS: Established practice needing BC/BE family practitioner with obstetrics background. Competitive salary/benefits for the area. Send CV to: Alpine Family Care, 1014 Centre Avenue, Fort Collins, CO, 80526 or call: 970-482-8881 fax: 970-482-3253. 04/1196

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05/0896

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◆ PROPERTIES FOR SALE OR LEASE

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RUMINATIONS

(def: chewing again what has been chewed slightly and swallowed; to **REFLECT**)

by **Bill Pierson**, Managing Editor

November 11, 1996: Seurre, a small town in central France on the Saone River: The weather is misty; a fog is settled along the river and covers the town. The "Bar de la Maritime" which faces the dock looks as if it is just waking from a sound night's sleep, rubbing its eyes. No hangover; the previous day was Sunday, so activity was minimal. A man inside is sweeping the floor along the bar. But today will be different. Already, at 10:00 AM there is a lone man standing in front of the Marwitime. He seems to be wearing a uniform of mixed sorts and has a brass horn hanging over his shoulder. Now I have it! He's a horn player in a band, but he's no youngster. And what's he doing standing around on a Monday morning? Surely, he's not waiting for the bar to open.

Walking through the wet cobblestone streets shrouded in fog and mist, I come to a town square, possibly 25 by 120 meters, and in the center is a statue. The figure is a soldier in full battle regalia, obviously of World War I vintage. On a plaque are the names of the men of Seurre who gave their lives in "The Great War" of 1914-1918.

And then I hear the band. Is it a parade? It is obviously a marching band, but the tune is nothing I recognize (i.e., Sousa). I follow the sound and come upon a slightly wider space in a street in front of a two-story building. The French flag is flying on either side of the door, which is raised from the street about three steps. On the top step are lined up (smartly) five or six older men. Each is wearing an

overcoat against the chilly mist, but on his breast each has his medals displayed. These are the veterans of that "Great War." They stand at attention as the band plays. In front of them stands a man who is of some official note. He turns out to be Mayor of Seurre, honoring these few World War I veterans still alive on this Armistice Day, 78 years later.

For a few moments, we're not far from such places as Argonne, Ardennes and Alsace-Lorraine, and other scenes of battle in past wars.

The Mayor is overflowing with his praise of the honored few. I don't understand his language but I know what he is saying. The small group of onlookers comes from farms or from corners of this town, each of them fleetingly in contact with the days those men served, possibly on trench-lined battlefields across France, even on Belgian or German soil, defending their country. For a little while there is a warmth and a drawing together of everyone there on that foggy, misty morning, as the band plays the *Marseillaise* and the veterans stand tall, as tall as age and infirmities will allow, looking very proud. This is a day in their honor.

After the musical and spoken tributes, the Mayor then turns and the doors of the Town Hall open. The smartly-uniformed veterans of the French Legion (about 20 of them) help the older veterans into the building where they all sit down for a special luncheon. The Mayor personally invited the members of the band to join him for lunch. The band marches off

"This was a very special day...."

down the narrow side street to the rattling beat of the snare drums, soon to disband. The parade is over. Townspeople go home. It is, after all, a holiday.

This is a very special day to these people, a farm town which had given its best in an effort to defend the country against a foreign aggressor. November 11th would always be "Armistice Day" in Europe.

I've known all my life what the day was, historically, but the meaning never reached me like it did this day. What extreme good fortune we in the USA have had. It reminded me of what great courage and grit the people of many nations have shown to fight back and to live again, some only to be conquered once more. It reminded me of the many U. S. citizens who had sacrificed in that and many wars not even fought on our own soil, but in defense of what we believe.

This was an Armistice Day whose meaning had truly come home to me as I stood there with them in their town... in their country... on their day.

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